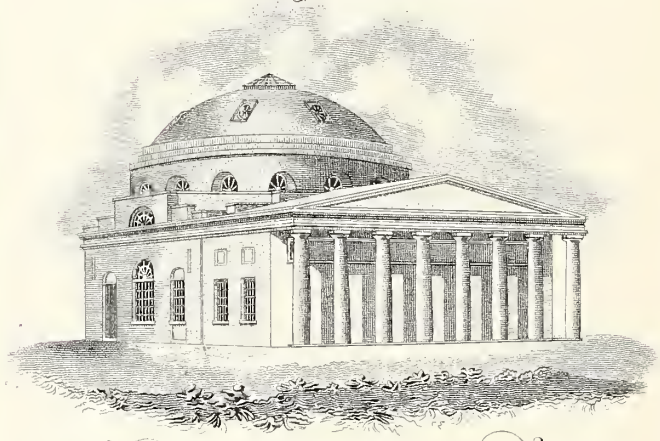
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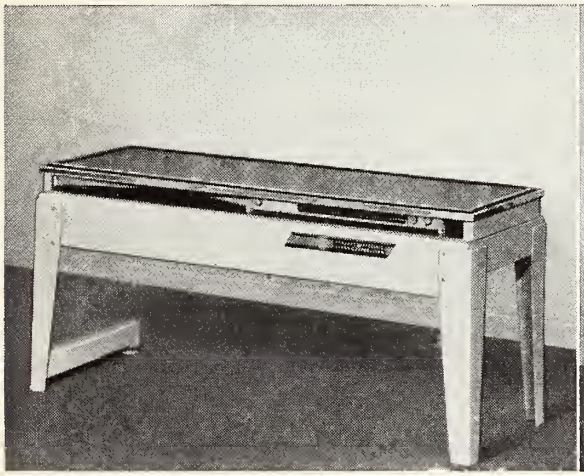
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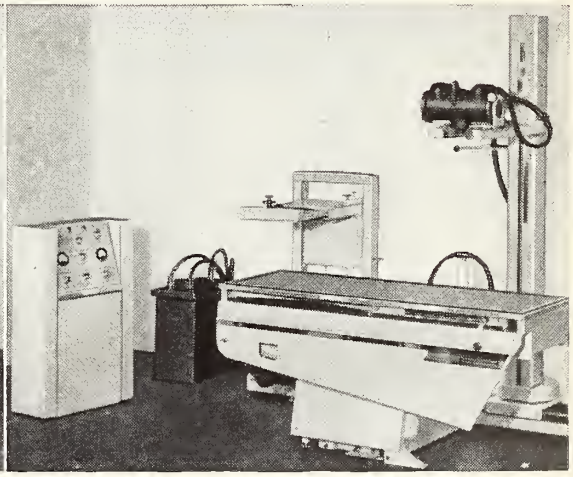
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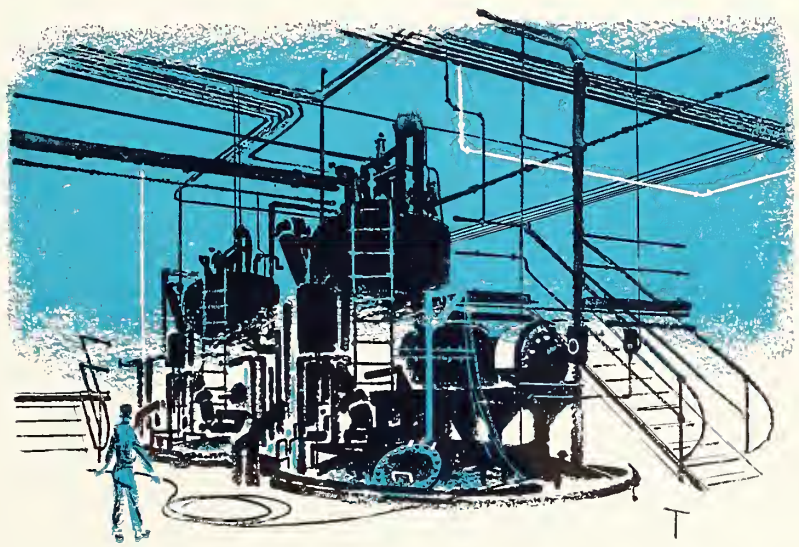
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ANESTHESIOLOGY—ITS ECONOMICS*

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CLAYTON, MISSOURI

AT NO TIME in the short history of the specialty of anesthesiology has a more serious threat been made to its existence than the statement of policy on "Physician Hospital Relations and Hospital Service Plans" by the American Hospital Association in March of this year. Its Board of Trustees approved a new resolution based on the idea of "services" being essential to the public, the physician and the hospital. These "ancillary services" were anesthesiologic, pathologic, physiatric and radiologic; and were to be included in prepayment hospital service plan subscriber certificates.

With this resolution the four specialties were placed in the same category with the operating room superintendent, the dietitian and the elevator boy; and, with heat, light and overhead in general OUR services would be offered to the public for a fee set by the hospitals, and the practice of medicine would be impersonalized, by delegating its control to a lay institution.

This resolution had been approved this year after the Hess committee's recommendations were rescinded last December, because some parts were considered illegal, and contrary to the responsibilities and prerogatives of hospital administration and management. It was the fear of the American Hospital Association that the hospitals' economic status would be impaired by the loss of certain controls and responsibilities which they considered to be traditionally theirs; namely, the control of the four specialties mentioned previously.

We in anesthesiology feel that an attempt should be made to stop and reverse, if possible, the alarming trend toward the sale of physician's services, particularly ours. However, those in our specialty can readily understand the reluctance with which hospitals would transform a highly profitable or "commercial" department into a fully professional one, with a consequent loss of revenue. Instead of exploiting one trained anesthesiologist, plus any number of nurses, the hospitals should attempt to attract to their staffs additional qualified men, having the patient's benefits in mind.

TOO FEW ANESTHESIOLOGISTS

But there are too few doctors in our specialty. It has been neglected. In Canada, Mexico, Sweden, England, France and Chile, to mention a few countries of the world, the practice of anesthesiology is the practice of medicine. However, the public in these United States, many members of the medical profession, and particularly hospital administrators, do not, or do not wish to recognize that fact. I except the state of Indiana.

Our recruitment of the high type of medical student and intern into our specialty has been poor until 1945. Prior to World War II there were few teaching centers in the field of anesthesiology. The attitude and character of most men in medicine giving anesthetics would not permit improvement of care to the patient. Theirs was a commercial activity; not indulging in teaching and study, not trying to give the knowledge available from the basic sciences to their anesthetic problems, but just trying to increase their incomes, in their spare time.

* Presented at the annual convention of the Indiana State Medical Association, in French Lick, September 27, 1950.

From this generally existent set of circumstances there arose a determination on the part of medical staffs of hospitals, and pioneered by Dr. G. W. Crile in 1907, to have nurse technicians available for anesthesia. So various training centers were set up, nurses were graduated and assigned and sent to hospitals throughout the country; and they provided a rich income to their particular hospitals. So now the medical student in his clinical years is accustomed to a surgeon saying, while waving his hand, "Nurse, give him some ether." Would you be impressed with the prestige, authority, and perhaps the income of this subordinate individual pouring ether? The nurses in anesthesia have done a good job, but they have discouraged and prevented many medical men from following that phase of the practice of medicine by their very presence. The surgeon directs them in their professional responsibilities, and the hospital employs and exploits them, so the American Hospital Association feels that this lucrative department, which has been in existence for the past forty-three years, should not be invaded by trained men who would practice medicine on a private fee basis. This is the background of what the American Hospital Association considers traditional control.

TRAINING

There are approximately six million persons anesthetized annually in this country, but there are only 3,200 members of the American Society of Anesthesiology, and only 700 members who are certified by the American Board. This leaves about 70 percent of the anesthetics in the hands of the part-time anesthetist and the nurse technician. Our American Society of Anesthesiology, realizing that there are too few men in the specialty to give the highest type of care to all patients, has set up more than a hundred training centers where the part-time anesthetist can improve his anesthesia. Although most of these centers are in the East, there is a nation-wide distribution, and 90 percent of these training centers are headed by teachers of residencies. Schedules are so arranged as to present the practical side and the part-time man may choose his time of attendance. His presence is fitted to his practice, and he may also have the advice and help of the training center by telephone, letter or personal visits. There is no fee connected with this type of improvement of patient care. The needs of the applicant have been individualized in this course, as to subjects and duration. The clinical aspect of the commonly accepted anesthetic procedures are emphasized with minimal stress on theoretic considerations. This program now constitutes one of the major interests of the American Society of Anesthesiology. The Section on Economics of the A.S.A. conducted a survey in the practice of medical anesthesia in the United States in 1949. It is felt that the findings of this survey are pertinent to this presentation. The general findings, and many times the exact wording of this survey, will be reported to you.

FEES AND METHOD OF PRACTICE

The Section sent 2,488 questionnaires to the A.S.A. members residing in the United States; 1,170 were returned, but only 1,093 of them were used for the basis of the report. There were two main categories used to evaluate the questionnaires, that pertaining to fees charged for anesthetic services, and that pertaining to methods of practice of anesthesia by physicians. Under fees for anesthetic service the survey attempted to learn what method physicians used in arriving at the fees charged for anesthetic services. Two questions were asked, as to whether or not fees were determined on a time basis and, if so, at what rate; and as to whether or not fees were determined strictly as a percentage of the surgeons fees. Twenty-nine percent reported that they computed their fees strictly on a time basis, and 65 percent reported that they did not do so. Some of the latter indicated that although they did not use a time basis strictly, it was used as a guide, with modifications based upon the patient's ability to pay, the difficulty of the case, the condition of the patient, and the type of hospital accommodations chosen. It was found that the rate for computing fees on a time basis, when given, varied so greatly that it was not felt worth-while to list them. Only 5.7 percent of the 1,093 reported that the fee for anesthetic service was computed as a percentage of the surgeon's fee. Rates, when given, varied from 10 to 20 percent. It is difficult for the anesthetist always to know the surgeon's fee for service.

Valuable information was volunteered by the members in replying to the two questions regarding the determination of fees. Many listed factors which they considered in arriving at a fee. For example, one physician wrote, "Fees determined by type of operation—duration of anesthetic, risk involved, and financial status of patient; at times, 15 percent of surgeon's fee is used." Another wrote, "We take into consideration a number of factors: length of operation, seriousness of the surgical procedure, surgeon's fee and ability of the patient to pay." In one case the physician stated "Fee depends upon type of room patient occupies, regardless of the length of operation." Another basis occasionally mentioned for determining fees was "Basis for fees is essentially time—based on workmen's compensation rates for New York State." The industrial rates for Ohio, Colorado and Florida were also mentioned as being used. In general, the four factors most frequently mentioned seemed to be (1) time, (2) to patient's ability to pay, (3) difficulty of the technique, (4) surgeon's fee. One member described an unusual method; stating that the county medical society fixed the anesthetic fee for all surgical cases at

$10.00; another wrote that "Hospital determines all fees—they are not known by the anesthetist."

The Section on Economics further requested information regarding the most common fee charged for eighteen specific surgical procedures, and classified the answers according to the geographical section of the country and according to the population of the community.

It was found that in general the average fees in the population groups of "under 5,000," "5,000 to 10,000," "10,000 to 25,000" are very similar. Above a community population of 25,000 fees increased with an increase in the population of the community, with the highest average fees for all procedures in communities with a population of over one million. This agrees with the report of *Medical Economics* on physician's incomes in considering "average incomes of independent physicians, by community size—1947." Both gross and net incomes of physicians increase with an increase in the size of the community, up to a population of a million and over.

The survey also revealed that the highest average fees, when considered geographically, exist in the Pacific section, with the Mountain section and the Middle Atlantic section placing second, about the same number of times each. Lowest fees exist in the New England section, with the West North Central section usually next to the lowest. The other sections of the country lie between these extremes, with a remarkable consistency in the position of each section of the country.

In this survey the question was asked, "What is your minimum fee?" As is to be expected, the average minimum fees for the various sizes of communities in the different sections of the country follow the pattern of the average fees given for the specific procedures previously. Communities with a population of less than 25,000 have about the same average minimum fee of $8.00 to $9.00. Above 25,000 and up to 100,000 the average minimum fee was $10.24. In communities over a million, the average minimum fee was $12.68. In a geographical sense, the Pacific area again has the highest minimum fee and New England the lowest.

Further knowledge was provided by this survey regarding the types of arrangements for reimbursement for anesthesia services rendered by physicians. The types of arrangements were listed as private fees, salary plus private fees, straight salary, salary plus percentage of receipts, straight percentage of receipts, and others. Eight hundred twelve of the 1,093 completed questionnaires were from physicians who derived their income from the private practice af anesthesia. In addition, 57 stated that their income was derived from a salary from an institution, plus fees from the private practice of anesthesia. The remainder of the anesthetists stated that they received their income from salary, salary plus percentage of receipts from a hospital department of anesthesia, or a straight percentage of receipts from a department. The data accumulated shows that about 75 percent of physician anesthetists are in the private practice of anesthesia, receiving remuneration on a fee for service basis. The large percentage of physicians in the private practice of anesthesia may be attributed to the fact that private practice allows four or five physicians to practice in one hospital, while a contract arrangement usually restricts the expansion of medical anesthesia in that particular hospital, and limits the number of physician anesthetists to one who supervises a group of nurses. The percentage of private fee practices gradually increases with increases in the population up to 25,000, where 91 percent of the physicians replying reported that they were in the private practice of anesthesia. In communities of 25,000 to 500,000 about 78 percent of the physicians reported a private fee arrangement. In communities with 500,000 to a million 61 percent of the physicians are in the private practice of anesthesia. This falls below the national average of 74 percent. When the population is over a million 58 percent are on a private fee basis. This latter figure is probably due to the fact that more of the teaching institutions and charity hospitals are located in the larger cities. Hospitals, rather than the physician, occupy a more dominant role in the provision of medical service.

In the survey the question was asked "Who bills the patient for anesthetic services?" About 77 percent of all anesthesiologists bill the patient for the anesthesia service; some said that this was collected by the hospital, and it is probable that the arrangements, other than private fees, are for the hospitals to collect the bill, although it was made up by the anesthesiologist. Sixty-six of 1,093 in the private practice of anesthesia stated that the hospital billed the patient for anesthesia.

These abstracts from the "Survey of the Practice of Medical Anesthesia in the United States" give one a clear picture of the average fee schedule, charge for anesthesia services, and the methods of practice of anesthesiologists.

Before closing, anesthesia for normal delivery should be mentioned. Since the advent of new "wonder drugs," hemorrhage and anesthesia have contributed more to the morbidity and mortality in obstetrics than infection. But due to the necessary night prowling, interference with the surgical schedule, and the inadequate remuneration received, we have, generally, neglected obstetrics, and the responsibility for its improvement rests squarely on the shoulders of our specialty. And we shall do our part.

The help of all men in medicine is necessary to combat the present trend of the sale of physicians' services. Obstetrics has been placed "on the block" in the West, and surgery in the East. We feel that

the withdrawal of approval of hospitals by the A.M.A. will not accomplish this. Bad practices in localities started this trend, and the local communities are the places to start correcting these bad practices.

SUMMARY

The following points were considered in this paper:

1. The resolution of the American Hospital Association approved by its Board of Trustees in March, 1950.
2. That organizations attempt to control what it calls "service departments."
3. Our sincere attempt to stop and, if possible, reverse the alarming trend toward the sale of physicians' services by corporations.
4. That the practice of anesthesiology is the practice of medicine.
5. That the American Society of Anesthesiology has established training centers for the training of part-time anesthetists.
6. Abstracts from the "Survey of the Practice of Medical Anesthesia in the United States," giving the average fee schedule for anesthesia service and methods for the practice of anesthesia by anesthesiologists were recounted.

CONSTRUCTION OF A PERMANENT SKIN-COVERED ILEOSTOMY

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FORT WAYNE

THE TREATMENT of ulcerative colitis is unsatisfactory and will probably remain so until the etiology is discovered. Medical treatment is, at best, only palliative. Ileostomy, with or without colectomy, remains the sheet anchor of surgical treatment. There has been a tendency in the past for surgeon, internist, patient, and relatives to postpone or even refuse ileostomy until the patient becomes so debilitated that a high mortality resulted following the procedure. Yet, as Lahey[1] states, "The decision for or against recovery in patients with severe ulcerative colitis is very often settled by the time an ileostomy is done." This aversion to ileostomy is understandable to anyone who has had the experience of caring for a severely emaciated and debilitated patient who has had the excruciating pain of skin excoriation produced by the leakage of ileal contents onto the surrounding abdomen added to his already miserable existence. These patients have been known to worsen their situation further by voluntarily reducing their intake in an effort to reduce the ileal discharge and thereby limit further skin excoriation.

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Recently the Koenig-Rutzen bag, a specially prepared rubber bag with a flanged cuff which is cemented to the skin about the ileostomy, has been quite effective in preventing skin excoriation. It has, as a matter of fact, revolutionized the outlook for patients with an ileostomy. However, it has certain inherent disadvantages. It is expensive and not readily obtainable at surgical supply houses throughout the country. Also, it requires the use of a skin cement which is messy and time-consuming.

Dragstedt and his associates[2] in 1941 reported a technique of ileostomy in which about 3 inches (7.6 cm.) of the terminal ileum was exteriorized. This was then covered with a skin graft forming a spigot of terminal ileum not unlike a penis, to which any of a number of simple appliances could be fitted to serve as a receptacle. This method of management has the disadvantage of necessitating a difficult skin graft which may be lost in the process. It has the obvious advantage that a variety of receptacles may be used.

Monroe and Olwin[3] in 1949 described a technique for constructing a permanent skin-covered ileostomy. This was accomplished by raising a pedicle flap on the right lower quadrant of the abdomen. The flap was reflected downward with its pedicle containing the inferior epigastric vessels. The terminal ileum was brought out through a small incision and the skin flap was wrapped about a length of the ileum and sutured in such a fashion

as to form a spigot or phallus-like appendage. The raw bed of the pedicle flap was covered with a split thickness skin graft. The entire procedure was accomplished in a single stage. A special prosthesis was constructed to fit snugly over the newly formed appendage and collect the ileal discharges. It would appear that such a technique should offer the advantages of the Dragstedt type of ileostomy without its disadvantages.

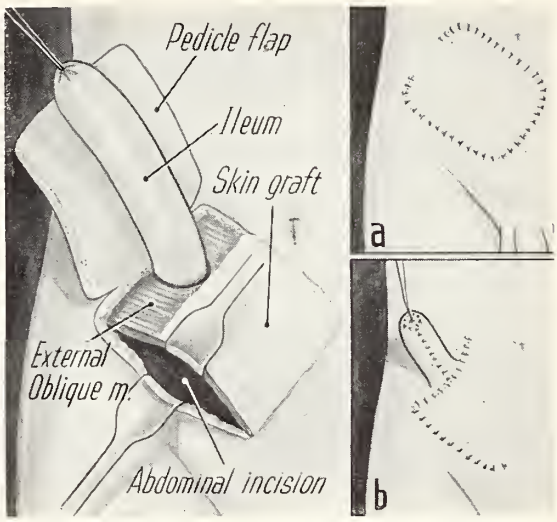
Recently a patient with ulcerative colitis was admitted to the hospital in whom an ileostomy seemed indicated. It was decided to follow the method described by Monroe and Olwin.[3] Minor modifications of their technique were thought desirable in order to obtain an appendage or phallus which would fit more snugly against the abdominal wall. It would, therefore, be less conspicuous beneath the patient's clothing. These expectations were fully justified by the postoperative result. Also, it was found that no special prosthesis was needed, an ordinary colostomy bag serving quite admirably. It is believed that a case report outlining the operative technique employed is justified, in the hope that this fortuitous result may be duplicated by others.

CASE REPORT

DWB R-46611, a 27-year-old white male, was admitted to the hospital on November 7, 1949, with a history of intractable diarrhea of five years duration. Medical treatment following his discharge from the Navy for ulcerative colitis had been of no avail. His general condition had worsened as manifested by ten to twelve often bloody diarrheal stools per day, weight loss, severe anal stenosis, and the development of multiple recto-urethro-cutaneous fistulae.

It was decided to perform an ileostomy preliminary to a total colectomy and excision of the rectum and anus. An abdominal pedicle flap was outlined on the right lower quadrant of the abdomen in a diagonal position, with the base or pedicle placed upward and outward. Three operative stages were utilized in completely elevating the flap in order to insure its viability. The first two stages were performed under local anesthesia. General anesthesia was utilized for the third stage, at which time a split thickness skin graft was placed in the raw bed of the flap which was again sutured back in place, thus burying the graft (see Fig. 1-a). Several weeks later a Miller-Abbott tube was passed under fluoroscopy and the patient was again taken to surgery. The flap was re-elevated and the underlying skin graft found to be intact and well healed. The abdominal cavity was entered by making a skin incision at the lower lateral border of the skin graft and splitting the underlying muscles (see Fig. 1). The terminal ileum was brought out through a separate small incision at the base of the pedicle flap. The pedicle flap was then wrapped around the projecting terminal ileum and sutured into place in such a manner that no raw areas remained (see Figs. 1-b and 2).

FIGURE 1



Abdominal pedicle flap has been re-elevated and the previously placed skin graft found well healed. The abdominal cavity is entered through a McBurney type incision at the infero-lateral aspect of the skin graft. The terminal ileum is drawn out through a separate small incision at the base of the pedicle. (See text.) a) Abdominal pedicle flap has been raised in three stages and a split thickness skin graft sutured in place beneath it. b) The flap has been wrapped around the ileum and sutured in place.

Postoperatively it was hoped that the small bowel could be kept deflated by means of the previously placed Miller-Abbott tube and that the operative site could be kept clean for a period of at least one week. However, mechanical difficulties with the Miller-Abbott tube developed, and the terminal ileum was opened at the bedside on the fifth postoperative day because of distention, vomiting, and discomfort. Immediately after opening the ileum it was found quite practical for the patient to keep the end of the phallus inserted into a urinal for collection of the bowel contents. Examination at this time revealed that the end of the ileum had retracted and in addition had undergone some necrosis so that no viable bowel mucosa was visible at the tip of the phallus. Also noted was some tendency towards stenosis of the orifice and a slight amount of irritation near the tip of the phallus. This gave the patient no discomfort since the entire appendage was anesthetic. The patient was taught to dilate the orifice daily with a gloved finger. Within several weeks bowel mucosa became visible and soon a perfect mucosa to skin union resulted around the entire circumference of the orifice.

During the first two postoperative weeks a number of temporary prostheses were tried. All proved quite cumbersome, time-consuming, and generally

FIGURE 2



Photograph of patient showing completed ileostomy.

unsatisfactory. It was finally discovered that an ordinary colostomy bag fitted quite snugly and was not conspicuous beneath the patient's clothing. This proved to be eminently satisfactory (see Fig. 3).

At the present time the patient has returned to his occupation as a draftsman. His health is greatly improved. The entire phallus is soft and pliable and there is no stenosis of the orifice and no skin irritation. The discharge from the stoma has gradually thickened until it is the consistency of soft mud but does vary to some extent according to his diet. The patient changes the colostomy bag morning and evening as a general routine. Occasionally an additional change is required during the day. A total colectomy and excision of the rectum and anus is contemplated at an early date, although the patient is enjoying such a sense of well-being that it is proving difficult to convince him that this procedure is advisable.

COMMENT

In the case described by Monroe and Olwin[3] the pedicle flap was formed with its base or pedicle directed downward and medialward in such a manner as to take advantage of the inferior epigastric vessels. The entire operative procedure, including the skin graft, was performed in one stage.

It was felt that a pedicle flap in the reverse position would result in a better cosmetic result by avoiding a conspicuous bulge beneath the patient's clothing. It was also believed that placing the skin graft at an early stage might better assure a 100 percent "take." Perhaps the multiple stages utilized were not necessary. This more cautious procedure of staging the operation was adapted for fear of endangering the viability of the flap since the inferior epigastric vessels were not utilized in its formation. By entering the abdominal cavity through a skin incision along one border of the skin graft, an additional operative scar was avoided.

FIGURE 3



Photograph showing snug fit of an ordinary colostomy bag over the phallus.

In retrospect it is felt that a smaller flap and thereby smaller phallus would have been just as satisfactory. For a time a revision of the phallus was considered because of its size. However the patient was getting along so well that this idea was abandoned.

The patient made a very rapid and completely successful return to his occupation and social life with very few restrictions. His daily toilet is no more difficult than that of the average patient with a colostomy and may even be simpler, in that an enema is never necessary. The type of colostomy bag used as a receptacle is cheap and readily obtainable at any surgical supply house. This method of management is to be compared to the use of the relatively expensive Koenig-Rutzen bag, with an extremely limited source of supply which necessitates the time-consuming and messy procedure of using specially prepared skin cements every time it is changed.

In view of the very satisfactory result reported by Monroe and Olwin[3] and the case here presented it is felt that further trial of this type of ileostomy is indicated.

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VALUE OF EXTERNAL CAROTID ANGIOGRAPHY IN THE SURGERY OF BRAIN TUMOR

Report of a Case

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THE VALUE of internal carotid angiography, in the localization and diagnosis of intracranial tumor, has been demonstrated in many recent articles. The place of external carotid angiography, on the other hand, has received only incidental mention. Egas Moniz, who originally advocated cerebral angiography, reported in an article in the Schweizerichemedizinische Wochenschrift, September 24, 1943, a case of sphenoid ridge meningioma, in which cerebral angiography demonstrated two meningeal arteries feeding the tumor. List and Hodges,[1] in *Radiology* (1947) also made mention of external angiography when they said "The external carotid artery provides the extracranial and dural circulation of the meningiomas. Since meningiomas may obtain their blood supply from both the external and internal carotid systems, a combination of angiography of the external carotid artery and internal artery is of definite value." French and Blake,[2] of the Division of Neurosurgery of University Hospital, in the *Bulletin of the University of Minnesota Medical Foundation* of February, 1949, also make brief mention of the value of external carotid angiography in the diagnosis and localization of meningiomas.

It is the purpose of this paper to report another case in which external angiography was of signal benefit in diagnosing and outlining an intracranial tumor, and to reemphasize the role of the visualization of the external carotid artery in the neurosurgical armamentarium.

The case was that of a twenty-five-year-old, married female, who, eighteen months previous to examination, had suffered what at that time was diagnosed as postpartum psychosis, following the birth of her first child. She had hallucinations, both visual and auditory, and was for a time under the care of a psychiatrist. Finding the restrictions imposed on her quite confining, she soon learned to deny the auditory and visual hallucinations, in order to regain her complete freedom. These phenomena, however, persisted and became slightly more severe. The patient also suffered from nagging headaches, which she did not mention, for fear of further psychiatric observation. The headaches became progressively worse, but were at no time severe. They were located over the right orbit.

At the time of examination, the family became alarmed because of a slight twitching of the corner of the right side of the mouth.

The neurological examination was almost completely negative. The visual fields were within normal limits. The fundi showed a slight blurring of the disc margins on the right, and on questioning, the patient admitted some blurring of vision on this side. There was no measurable papilledema. The left disc was within normal

FIGURE 1



Lateral of plain skull.

FIGURE 2



Lateral Pneumo-encephalogram.

limits. The patient seemed to have some mood changes, and to be more than usually irritable and apprehensive. On close questioning, the husband stated his wife's disposition had not been as good as at the time he married her.

There was a questionable weakness of the corneal reflex on the right, but this was not definite. The remaining cranial nerves were intact. There was no pass-pointing, no nystagmus, no astereognosis, and no adiadochokinesis. The deep tendon reflexes were equal and physiological. There was no Hoffman and no Babinski. The sensation, except for the questionable hypaesthesia of the cornea on the right, was within normal limits. The patient showed no abnormality of gait, but her speech and gait were a little hesitant, which was attributed, by the family, to the fact that she was still suffering from past phychiatric difficulties.

Because of the combinations of hallucinations, plus slight blurring of the discs, the slight twitching of the mouth, and the headache, it was decided that she have a pneumo-encephalogram and carotid angiogram. When the pneumo-encephalogram was performed, the shift of the ventricles to the opposite was so remarkable, in comparison to the paucity of neurological findings, that it was felt the patient must be suffering from a tumor, extrinsic to the cerebral cortex, rather than an intrinsic one. The symptoms also made one think more of a meningioma than a malignant tumor. Because of the position of the tumor, evidently in the temporal area, as seen by the pneumo-encephalogram, it was decided that an external carotid angiogram might possibly fill the feeding vessels and thereby outline the tumor completely. The films are herein presented.

The first film is lateral of the plain skull, and it will be noted there are no calcifications, no erosions, or other identifying markings which might indicate the type or position of the tumor.

The next picture is a lateral pneumo-encephalogram, which indicates, but does not outline the tumor.

The third picture is an AP, which shows a marked shift of the ventricles to the left.

The fourth picture is that of the filling of the external carotid artery, and it will be seen at once that the tumor is outlined completely. It is shown to be well demarcated, and the size and position are exceptionally well portrayed. With this picture of the tumor, the neurosurgery was rendered simpler and easier, with the knowledge that the middle meningeal artery supplied the tumor in most part.

An extradural approach was first made and the middle meningeal artery clipped. The dura was

FIGURE 3



A. P. Pneumo.

FIGURE 4



Lateral Angiogram.

then entered, and a tumor, the size of a large lemon, obviously extrinsic to the cortex, a meningioma, was discovered lying underneath the temporal lobe, extending all the way to the sella turcica. The removal of the tumor was not complicated with the usual profuse bleeding, since the main blood supply had already been cut off.

The tumor was removed in toto, and its attachments to the dura thoroughly coagulated. The patient made an uneventful recovery. She left the hospital in ten days apparently well. It is interesting to know that the auditory and visual hallucinations disappeared. The vision in the right eye improved almost to normal during hospitalization, and the patient suffered no more convulsive movements of the angle of her mouth. On examination one year later, she appeared completely recovered.

SUMMARY

A case of sphenoid ridge meningioma, supplied by the middle meningeal artery, has been presented, in which external carotid angiography outlined the tumor, as to size and configuration, with such exactitude as to simplify the surgery. The problem of the source of the blood supply to the tumor was solved by the angiography, and this fact made the operation much easier. It is suggested that in certain types of tumors, external carotid angiography may be of unusual value.

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VOLVULUS OF THE CECUM

Report of Two Cases

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VOLVULUS of the cecum represents an interesting and unusual type of intestinal obstruction. It is a rare cause of obstruction, probably accounting for not more than ½ to 1 percent of the total number of intestinal obstructions.[1,2,3,4,5,6] The preoperative diagnosis is not commonly made, and the management may be difficult and serious, with an average mortality of about 40 percent. For these reasons it was felt that a review of this condition along with our experience in the management of two cases might be of general interest.

The etiology of this lesion is not well understood. Wolfer[1] and others, after a study of 125 normal adult cadavers, demonstrated that 11.2 percent had a cecum mobile enough to allow the development of a volvulus. They point out that the anatomical arrangement which best predisposes to cecal volvulus is probably one in which the cecum is free and the ascending colon somewhat fixed along its vertical course. It was their impression that the mechanism of volvulus varied greatly, but that it seemed to depend chiefly upon the anatomical relationships and upon the position of a fixed point, or points, for twisting. Most studies indicate that from 10 to 15 percent of patients have a cecum which is mobile enough to permit twisting. In view of this rather high number of mobile cecums, one wonders why the incidence of the disease is not higher. There must be other anatomical factors which affect or influence the causation of twisting of the cecum and first portion of the ascending colon. A probable one is some fixation of the ascending colon in order to form a hub about which the cecum and terminal ileum can rotate.

In addition to anatomical factors, precipitating ones, such as violent purgation, trauma, pregnancy, tumors and operative procedures may come into play. A survey of the literature indicates that the condition is most often seen in young adult males and that the factors of age and sex have some effect on the incidence of the disease.[4]

SYMPTOMATOLOGY

The main complaint is that of crampy abdominal pain, usually generalized in nature, or perhaps localized to the lower abdomen. This may be associated with nausea and vomiting and a certain degree of obstipation. Since, however, there are several feet of uninvolved colon distal to the point of obstruction, the patient may have a bowel movement or may pass flatus. On physical examination the abdomen is usually found to be moderately distended, and one can frequently palpate a distended mass which may be in any part of the abdomen, but which perhaps is most often in the left upper or left lower abdominal quadrant.[4] Tenderness is usually present, particularly if the lesion is strangulating in type. Auscultation may reveal exaggerated small bowel peristaltic sounds and tinkles, since the patency of the ileocecal valve may be compromised. The symptomatology may vary somewhat, depending on whether or not the volvulus is of the so-called acute, or of the subacute, recurring type. In the acute type there is a complete, or nearly complete obstruction of the lumen of the bowel due to its being twisted upon itself, and there may be impairment of the blood supply to the involved loop. In the subacute type the twisting is not so great, the degree of obstruction is less, and the symptoms are not so violent. The twist in the bowel may relieve itself spontaneously, only to recur at some later date. Some authors classify this as the chronic, recurrent type.[7]

DIAGNOSIS

The disease is most often seen in young people, although it may be seen in any age group and is said to be more common in men than women, the ratio being about two to one.[5] As noted above, these patients complain of abdominal pain, which is usually crampy in nature, and which is usually associated with some vomiting and a moderate degree of constipation. The finding of a tender mass in the abdomen is helpful. The disease must be distinguished from other types of intestinal obstruction and is apt to be confused with volvulus of the sigmoid colon, adynamic ileus, and twisted adnexal tumors. Organic obstruction of the transverse or left colon, as well as small bowel obstruction in the region of the ileum, are apt to present a picture somewhat resembling that seen in volvulus of the cecum and terminal ileum. The roentgen examination of the abdomen is a very important aid in distinguishing the condition. It is possible to make the diagnosis from the flat film of the abdomen. The roentgen criteria for the diagnosis, as pointed out by McGraw,[2] are as follows: 1. Dilated cecum lying in a very abnormal position. 2. Loops of small bowel lying to the right of the distended cecum. 3. The observation of the ileocecal valve lying to the right of the distended viscus may be absolutely diagnostic. 4. A cone-shaped obstruction of the ascending colon with spiral mucosal folds, demonstrated on barium enema examination, is likewise diagnostic. 5. Us-

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ually only a single fluid level is present in the colon when upright films are made.

REPORT OF CASES

Case No. 1: A white female, aged 82, was admitted to Welborn Memorial Baptist Hospital on October 29, 1945, with a complaint of abdominal pain. She at first developed a low back pain about four days prior to admission. She had noticed this while she was bending over to tie her shoe. It had persisted for a few days, but on October 28 she first noted cramp-like pain in the left lower quadrant of the abdomen; the cramps tending to recur at intervals of fifteen to twenty minutes. She vomited occasionally after the ingestion of liquids. She took an enema but failed to pass gas or any fecal material. The pain persisted throughout the twenty-eighth and twenty-ninth of October, and at 8:00 P.M. on that date she was admitted to the hospital. There was no history of any alteration in the bowel habits, nor was there any history of blood in the stool, although the patient had not observed the color of the stools very closely. She had been in good health. She had been seen in 1938, at this hospital, at which time x-ray examination of the colon was carried out with a diagnosis of colitis.

Physical examination revealed an acutely ill, elderly white female, complaining of pain in the abdomen. The blood pressure was 184 systolic, 110 diastolic. The temperature on admission was 98.6, and the pulse rate 94. The tongue was furred and somewhat dry. The remainder of the examination, aside from the abdomen, was relatively unimportant. Moderate abdominal distention was noted and this seemed to be most marked in the left lower quadrant of the abdomen. In this area an irregular mass, which was tympanic on percussion and slightly tender, was delineated. Peristalsis was present but not increased. The rectal examination was not helpful. Pelvic examination revealed the vaginal mucosa to be atrophic, and at this time bimanual examination again revealed an indefinite, irregular mass which seemed to be filling the left side of the abdomen and the brim of the pelvis. The admission impression was that of partial large bowel obstruction, possibly due to volvulus of the sigmoid colon, or carcinoma of the rectosigmoid juncture. The possibility of a twisted ovarian cyst was also entertained. Radiographic examination of the abdomen, including flat films and barium enema, was carried out. The rectum appeared to be normal. There was considerable redundancy of the sigmoid colon and a number of small diverticula were visualized in this area. Fair haustralization in the descending, transverse, and ascending colon was noted. The cecum and ascending colon extended toward the midline. A large amount of gas was visualized in what was interpreted as being loops of small intestines. One loop of small bowel seemed to be markedly dilated. The roentgen impression was that of obstruction in the small intestines in close proximity to the cecum. Figure 1

FIGURE 1



Flat x-ray film of the abdomen in Case 1. Note the large, dark, rounded shadow, faintly outlined by arrows, filling the left lower quadrant of the abdomen. At operation this was revealed to be the gas-filled cecum.

is a reproduction of the flat film of the abdomen taken on the patient's admission. A rounded, dark shadow, almost completely filling the left half of the abdomen, and faintly outlined by arrows, can be seen. Figure 2 is a reproduction of the x-ray film after barium enema. The dark shadow, faintly marked by arrows, is again seen. The significance of these shadows was not fully appreciated until after surgery, and will be commented on later. The red blood cell count was 4,520,000, white blood cell count 25,150, with a hemoglobin of 100 percent. The differential blood count showed 85 percent polymorphonuclear leukocytes and 15 percent lymphocytes. The urine was straw in color, acid in reaction, specific gravity 1.026, 2+ albumin, with negative sugar. There were a few blood cells and a few hyaline casts in the centrifuged sediment.

The patient's dehydration was corrected by means of intravenous fluids, and she was explored through a lower midline incision approximately twenty-four hours after admission. Exploration of the contents of the peritoneal cavity revealed the cecum to be enormously dilated, lying transversely across the lower abdomen, and rotated in a clockwise manner 360 degrees. A little blood-tinged fluid was encountered. There were some adhesions between the greater omentum and between loops of moderately dilated small bowel lying nearby. Apparently this rotation had been caused by a band which partially obstructed the ascending colon, and which seemed to extend from the region of the terminal mesentery of the terminal ileum laterally across the

FIGURE 2



Barium enema in Case 1. The lumen of the colon to the level of the cecum is patent. Note the dark shadow, faintly outlined by arrows.

FIGURE 3



Flat x-ray film of the abdomen in Case 2. Note the ovoid, dark shadow, in the left upper quadrant of the abdomen. At operation this was found to be the dilated, gas-filled cecum. The stomach must be excluded as a cause for such a shadow by passing a Levin tube and aspirating the contents, or by injecting a small amount of radiopaque material.

ascending colon to the lateral folds of the parietal peritoneum. This band was freed, and the cecum delivered through the wound on to the abdominal wall. Detorsion was carried out by rotating the cecum in a counter-clockwise manner. Fluid and gas seemed immediately to escape into the ascending colon, relieving the enormous distention of the cecum. One small subserosal hemorrhage was noted on the wall of the cecum, but otherwise the bowel wall seemed to be viable and the contractility of the musculature normal. Warm sponges were applied to the cecum; it was gently massaged and returned to the peritoneal cavity without further manipulation. There did not seem to be any tendency for the volvulus to recur. The wound was closed in layers without further manipulation and without drainage.

The patient's postoperative course was uneventful. The day following operation peristalsis was noted to be present and the patient was passing flatus and liquid stools by rectum. There was no evidence of recurrence of the volvulus. Since the patient was elderly, and had some arthritis of the spine, she remained in the hospital, mainly for nursing care, being discharged on December 5, 1945, in good condition. She has subsequently remained well.

Case No. 2: A white female, age 68, was admitted to Welborn Memorial Baptist Hospital, January 9, 1949, with a ninety-six hour history of cramping, abdominal pain, abdominal distention, and inability to reduce an incisional hernia. She had been nauseated and had vomited some yellowish colored fluid prior to admission. She stated that her last bowel movement was scanty and had been about twenty-four hours prior to hospitalization. There was no history of alteration in bowel function. She had been operated on approximately twenty years ago through a median, suprapubic incision, apparently for uterine suspension. She had developed a hernia following this which had gradually increased in size, but which she thought she had always been able to reduce. Prior to the present admission, however, she thought that she had had more difficulty in reducing it than usual. This patient had been admitted to the hospital on August 16, 1948, with a diagnosis of arteriosclerotic heart disease, decompensated, stasis ulcers of both lower extremities, with severe, secondary infection and cellulitis, and chronic cystitis. She had been readmitted on December 9, 1948, again in congestive failure. She had improved with digitalis and mercurial diuretics. On both admissions the large, incisional hernia described above was noted.

Examination on the present admission, January 9, 1949, revealed an elderly, white female lying flat in bed complaining bitterly of pain in the abdomen. She was found to be poorly developed and poorly nourished. The skin was sallow in appearance, with a suggestion of slight cyanosis of the nailbeds. The neck veins were moderately distended and a few rales were present in both bases. The heart was enlarged to percussion and there was a loud systolic murmur noted at the apex. The cardiac rhythm was grossly irregular.

The liver edge was palpable approximately two fingerbreadths below the right costal margin. Examination of the abdomen revealed a large herniation through a previous lower midline incision. There seemed to be some distended loops of bowel present in the hernia, but it was soft and only slightly tender. In the left upper quadrant of the abdomen there was a smooth, somewhat tender mass. Auscultation revealed the bowel sounds to be hyperactive with metallic tinkles present. Radiographic examination of the abdomen was carried out on January 10, 1949, at which time considerable gas was noted in the large intestines. An incidental finding was that of marked narrowing of the first and second lumbar vertebrae with calcium laid down in the soft tissue just lateral to the first and second lumbar vertebrae. Figure 3 is a reproduction of the scout x-ray film of the abdomen. A dark, rounded, ovoid shadow in the left upper quadrant of the abdomen may be seen. The patient's temperature on admission was 99, pulse rate 90, and the blood pressure 180 systolic and 100 diastolic. The red blood cell count was 4,350,000, with 13,600 white cells and 13 grams of hemoglobin. The urine was straw in color, alkaline in reaction, and the specific gravity was not determined. There was 30 mgm. % albumin and no sugar. The centrifuged sediment showed two to three white cells and ten to twelve red cells to the high dry field.

She was seen in consultation the day following admission, January 10, 1949, by Dr. Earl H. Antes. He found the heart to be greatly enlarged and the rhythm to be grossly irregular. There were many congestive rales at both bases of the lung, with congestion of the cervical veins. He noted that she was lying flat in bed with Cheyne-Stokes respiration. He felt that the patient was obviously too ill to recover from any type of major surgical procedure, and advised nasal oxygen and other supportive measures. The patient continued to complain bitterly of abdominal pain and, in spite of being such a poor risk, was brought to surgery on January 12, 1949, with a preoperative diagnosis of possible volvulus of the sigmoid colon.

She was explored through a low, transverse, abdominal incision, placing the incision just above the huge incisional hernia previously described. On opening the peritoneal cavity a large, distended, dark colored loop of bowel presented itself. There was a small amount of bloody fluid. Careful inspection of this mass revealed it to be a twisted, dilated cecum, which seemed to fill the left side of the abdomen and extend upward towards the left upper quadrant. The cecum had rotated upon itself in a clockwise manner 720 degrees. It was detorsed by rotating it in a counter-clockwise manner, and following this maneuver flatus escaped into the ascending colon. A peritoneal band was found to extend from the parietal peritoneum of the right lumbar gutter across the ascending colon medially and inferiorly towards the region of the mesentery of the terminal ileum. This was freed. The cecum was manually manipulated in order to promote the escape of gas and liquid material into the ascending colon. Three interrupted sutures of 00 chromic catgut were used to tack the epiploic appendages of the cecum to the parietal peritoneum in the right iliac fossa. This maneuver was carried out with the thought of preventing a recurrent volvulus of the cecum. The large incisional hernia was inspected and was found to be free of strangulated or incarcerated bowel. It was examined and then ignored, the abdomen being closed in layers, without drainage. On the first postoperative day the patient ceased vomiting and improved sufficiently to permit her removal from an oxygen tent. Her postoperative course was slow but uneventful, aside from slight separation of the midportion of the wound edges. She was discharged from the hospital on January 25, 1949, and died several months later of heart disease.

TREATMENT

A discussion of the treatment of this condition was postponed until the two cases reported here were recorded. The treatment in the acute cases, such as the two reported, is surgical. It is possible that some of the partial or subacute cases, or those with chronic recurrence, may spontaneously relieve themselves, or may be relieved by enemas. The surgical procedures carried out will vary somewhat, depending on the nature and condition of the bowel found at the time of surgery. In the two cases herein reported the cecum was thought to be viable in both instances, although the duration of the illness had been for several days prior to surgery in each one. In Case No. 1 the cecum was simply detorsed, the peritoneal veil across the ascending colon was divided, the cecum was partially emptied by manual compression and no other maneuvers carried out. In the second case, a band across the ascending colon, partially fixing it, was also revealed, and the band was also freed. Here, too, the cecum was decompressed by manual pressure from wet sponges and partially evacuated. A few epiploic appendages, however, were sutured to the lateral fold of the peritoneum in the right iliac fossa in order to aid in preventing recurrence of any twisting of the cecum. If the involved bowel is not viable it must be resected. In general it would seem to be much wiser to exteriorize the devitalized bowel after the method of Mikulicz, rather than to attempt resection with primary anastomosis, either by an open or a closed method. Most authors seem to feel that it is wise to attempt to fix the cecum after detorsion in order to prevent recurrence of the twisting.[1] This can be accomplished by a variety of means, some of which are cecostomy, appendicostomy, or plication of the peritoneal folds of the cecum. Dixon[3] has described a method whereby the parietal peritoneum of the right iliac fossa is elevated, the cecum is pushed underneath it, and the fold of peritoneum then sutured medial to the cecum at

the edge of the mesentery of the terminal ileum. This maneuver places the cecum and ileocecal valve in an extraperitoneal position in the right iliac fossa.

COMMENT

Two cases of acute volvulus of the cecum are reported in this paper. Both of these cases occurred in women in the elderly age groups and both recovered. A review of the literature reveals that the condition is most commonly seen in males and in young adults, and that the mortality averages from 40 to 50 percent. In this respect our experience has been unusual. Another interesting anatomical finding was that of a peritoneal band which seemed to fix the ascending colon and to aid in the formation of a hub, about which the cecum and terminal few centimeters of the ileum could rotate. In view of the fact that the rotation in these cases was in a clockwise manner, as in the others reported in the literature, one wonders whether or not this fixation of the ascending colon is not an anatomical prerequisite, and that the inciting factor is hyperperistalsis; the peristaltic waves striking the ileocecal valve from left to right, causing the cecum to rotate in a clockwise direction. Wolfer[1] and others alluded to this factor in their paper and pointed out that the mechanism for volvulus probably varied greatly, but that it seemed to depend chiefly upon the anatomical relationships and upon the position of a fixed point for twisting.

These observations would seem to furnish strong evidence that in addition to a mobile cecum one must also have a fixed point in the ascending colon in order to have volvulus. If this were not so, and in view of the fact that 10 to 15 percent of people have mobile cecums, the incidence of the disease would seem to be higher. Additional evidence, also tending to support the thought that a peritoneal band partially fixing the ascending colon is necessary anatomically before volvulus can occur, is that in both of these patients simply freeing this peritoneal veil without added manipulation, except in Case 2, was done without recurrence of the volvulus. In Case 2 an effort was made to fix the detorsed cecum to the parietal leaf of the peritoneum in the right iliac fossa. In Case 1, however, the band fixed to the ascending colon was simply divided, the cecum detorsed and partially decompressed by manual means and then returned to the peritoneal cavity. However, until both the predisposing and inciting factors are better understood, it would seem safer to fix the cecum to the parietal peritoneum by some procedure, such as cecostomy or appendicostomy. In cases of recurrent and subacute volvulus, in which there is minimal distention of the cecum, the method described by Dixon[3] of elevating a fold of the parietal peritoneum in the right iliac fossa and suturing it superficially to the cecum seems to be a good method of preventing recurrence.

The correct preoperative diagnosis was not made in either patient. In retrospect, it would seem that this could have been done had there been a closer correlation of the x-ray and the clinical findings. In Case 1 the flat film of the abdomen revealed what appeared to be a large, gas-filled loop of bowel partially filling the lower abdomen, and barium enema demonstrated the patency of the intestinal tube to the level of the cecal region. These findings, plus the clinical demonstration of a rounded mass in this area, should have made the diagnosis possible.

In Case 2 the flat k-ray film of the abdomen revealed a large gas shadow in the left upper quadrant of the abdomen. Here, too, physical examination revealed a tender, rounded, smooth mass. If at this stage of the patient's study the stomach had been excluded as a source of the trapped gas by passing a Levin tube, here, too, it seems in retrospect, the correct preoperative diagnosis could have been made.

SUMMARY AND CONCLUSION

Volvulus of the cecum is an uncommon but important cause of intestinal obstruction. Its incidence is probably ½ to 1 percent of all intestinal obstructions. It seems to be a disease of young male adults. However, it can occur in any age group. A predisposing anatomical factor is a mobile cecum, and a probable necessary prerequisite is fixation of the ascending colon. The precipitating causes are vague. The treatment is surgical, and the mortality in the reported cases is approximately 40 to 50 percent. Simple detorsion, with fixation of the cecum by cecostomy, or appendicostomy, is the operative procedure of choice. If the bowel is devitalized, exteriorization, after the method of Mikulicz, is indicated. Two cases in elderly white females are reported, both of whom were operated and recovered.

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Case Report

CUTANEOUS SPOROTRICHOSIS

Report of Two Cases

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SPOROTRICHOSIS is a rare disease, but the clinical characteristics of the cutaneous forms are so typical that it can often be readily diagnosed by inspection only. Since this disease may terminate fatally if not recognized and properly treated, we feel that the profession should be better acquainted with it. This is particularly true since potassium iodide offers practically a specific treatment.

Sporotrichosis is endemic throughout the Middle West. It is caused by the fungus, Sporotrichum schencki. Most writers believe it is usually contracted from plants. The two cases reported would add further evidence toward this view. Foerster[1] reported ten of his eighteen cases developed after injuries sustained by thorns of the barberry shrub.

The most common type of sporotrichosis encountered is the localized lymphatic type.[2] The first evidence of the infection is a nontender or slightly tender nodule which appears in from one week to three months at the primary site of inoculation, which is usually on the hand. This nodule becomes necrotic and ulcerates, forming the so-called sporotrichotic chancre. By the time the chancre has developed, red nodules have often appeared along the course of the lymphatic vessels, draining the region at the site of the primary ulcer. These nodules also become necrotic, forming ulcerations similar to the initial lesion. The patients are usually afebrile, which helps to differentiate it from the ulcero-glandular type of tularemia. Also, the nodes and subsequent ulcers appear along the lymphatics, rather than the regional lymph nodes as seen in tularemia.

CASE 1

C. U., aged 42, a white man, was employed as a horticulturist. He was hospitalized because of an ulcer of unknown etiology on the right dorsal thumb. The lesion had appeared about two weeks after he had pricked his thumb with a thorn while carrying a barberry bush. The lesion had increased in size despite the use of various medications prescribed for local application by his attending physician. He was found to have several nodules extending along the course of the lymphatics of the right arm and forearm. Some of these lesions were beginning to ulcerate. Repeated dark-field examinations for Treponema pallidum were negative. The S.T.S. was negative. No fungous elements were found on direct examination, but cultures which grew on Sabouraud media inoculated with scrapings from the ulcers were identified as Sporotrichum schencki. The patient was treated with fifteen minims of potassium iodide by mouth three times a day, and after two weeks he was discharged with all lesions healed.

CASE 2

L. S., a 5-year-old white boy, was first seen in the office because of an ulceration 3 x 3 cm. in diameter on the flexor surface of the forearm. Several tender nodules had assumed a linear formation up the forearm and arm. The primary ulcer had appeared four weeks previously without a history of injury. However, the boy's favorite play place was bordered on two sides by some barberry bushes. He had received several injections of penicillin in oil without improvement.

Cultures made from pus from the ulcer grew a fungus which was identified as Sporotrichum schencki. After three weeks of potassium iodide therapy the nodules had resolved and the ulcer had healed. The therapy was continued another three weeks to prevent a possible relapse.

SUMMARY AND CONCLUSION

Two cases of sporotrichosis of the localized lymphatic type are reported. The source of both infections was probably through the prick of a thorn on the barberry bush. These two cases add further evidence to single out this plant as one of the chief intermediary hosts of Sporotrichum schencki. The clinical appearance of the lesions are sufficient to enable one to make a tentative diagnosis in most cases. This diagnosis can be substantiated by inoculating Sabouraud media at room temperature with scrapings taken from the ulcers. Potassium iodide appears to be specific for this disease.

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WALKING BLOOD BANKS

AS SOON as it became evident that large amounts of blood would be required for transfusing some of the victims of a possible atomic bombing, civilian defense committees, blood bank personnel, and interested physicians began discussing the proper method of meeting such a need.

At first it was proposed that a universal blood typing program be instituted, and that everyone in the United States be typed, so that anyone, in the event of an emergency, could be cross-matched with a donor of the proper group, if transfusion was indicated.

Later it was suggested that the "universal donor" system, which was such a success in World War II, be adopted. The Army and Navy medical services used large quantities of type 'O' blood without cross-matching during the last part of the war, and with practically no reactions.

This method is well adapted for atomic disasters, since it allows most of the laboratory work to be done beforehand, and provides safe transfusions with a minimum of laboratory work required under stress of the emergency.

In short, the plan provides for the pretyping of the donors, instead of pretyping of all possible recipients and then cross-matching after the emergency develops.

At first glance it appears that typing donors instead of recipients is a distinction without a difference. However, by typing only the donors one may eliminate those who are too young, those who are too old, and those who are so chronically ill that they could not give blood. This reduces the total number by one-third, and considerably lightens the burden.

After a large number of possible donors have been typed, the type 'O' donors (approximately 47 percent of the population) would constitute a "walking blood bank." In case of a large scale emergency they would be able to contribute blood as it is needed, and the blood could be used with a minimum amount of technical help.

Some have felt that this plan is inadvisable because of unavoidable errors in typing a large number of people, and because the supplies of typing serum are limited at present. However, both these drawbacks would be much worse if the typing were to be done in the midst of a catastrophe. Any work that can be done now will be more accurate, and should be done to the limit imposed by typing serum supplies.

Another advantage of precatastrophe typing is suggested by the Civilian Defense Committee of the Indianapolis Medical Society which proposes that

the results of the typing procedure be checked by retyping each prospective donor at a time subsequent to his original test. This can be done as supplies of typing serum increase and will provide a highly accurate determination.

The "walking blood bank" plan fits well into the blood derivatives program. At present large quantities of blood must be obtained for the purpose of providing stores of plasma and other blood products; many prospective donors may be typed as a part of this program, and may be used as emergency donors later.

The Committee on Policy of the National Blood Program of the American Red Cross has issued the following statement: "It is recommended that all blood bank facilities be urged to continue to develop registers of typed donors as part of their regular operations, as is now being done in many independent blood banks and in the Red Cross Regional Centers. Every attempt should be made to confirm the group 'O' donors among the large number of men whose blood was grouped in the Armed Services during the last war. Each donor should be given a card indicating his group and the date and place [at] which this was done."

The Committee on Blood Banks of the A.M.A. is following a pilot study in Jackson County, Michigan, and hopes to learn many facts which will be of use in future typing programs. This committee is also interested in ways of improving the supply of the necessary serums.

It is also pointed out that all prospective donors of whatever type should preserve their typing cards, since the need for transfusions will extend for some atomic casualties into a period of several weeks. As the confusion subsides and as the main load of casualty treatment tapers off, cross-matching may be done, and it will be possible to utilize donors of the 'A,' 'B,' and 'AB' groups.

The medical profession should be interested mainly, for the time being, in aiding the procurement of stocks of blood for blood derivatives, in encouraging the typing of all donors who visit blood banks, in accumulating rosters of people who have been typed previously, and in aiding in the adequate training of technical assistants for the operation of blood stations.

As the supply of typing serum improves the typing of all prospective donors and the tagging of group 'O' donors should be pushed to completion.

IMPROVEMENT OF NURSING

THE IMPROVEMENT of nursing in Indiana has been made the principal aim of three of the state's nursing organizations. Several committees have been formed to determine the needs of the situation and to formulate long range planning. At the same time work is being started now on the most urgent and feasible portions of the program.

The Indiana State League of Nursing Education, The Indiana State Board of Nurses' Registration and Nursing Education, and the Indiana State Nurses' Association are pooling their resources for this important project.

These organizations have formed a Joint Committee for the Improvement of Nursing in Indiana. Subcommittees are functioning for each of the major problems.

There are now approximately 9,000 actively practicing registered nurses in the state. It has been obvious for some time that there is need for more. One of the objects of the survey will be to determine how many nurses are needed to render the various nursing services that are essential.

There is also, at present, a shortage of nurse educators, especially teachers of clinical nursing. Ways and means of correcting this are being studied.

One of the hindrances to the training of nurses has been the lack of clinical teaching facilities. This is being at least partially solved by the interchange of students between hospitals.

Quite a number of training schools have been handicapped because of the inability to provide residences for student nurses. An example of the efficacy of the coordinated planning is afforded by the school which was able to obtain clinical teaching facilities through affiliation with another school, and was thus enabled to obtain necessary funds locally for a nurses' residence when it was assured that it could graduate its students with a complete education.

One of the subcommittees is making a functional analysis of nursing duties. The object of this will be to determine whether a nurse's tasks may be simplified by the adoption of new techniques.

Another subcommittee will study in particular the problems of recruitment and education in the Public Health Nursing field.

Methods of improving the training of practical nurses and nurses' aides are being sought. Of the 7,200 practical nurses in Indiana, only some 10 percent have had any formal training. At the request and with the cooperation of the practical nurses' organization, a sixty-four-hour standardized course will be given for the benefit of those who need additional instruction.

These studies are being conducted with the cooperation of the Indiana State Board of Health and

the Indiana State Medical Association. The survey is being coordinated with the work of the Committee to Implement Recommendations of the Indiana University Workshop on "Nursing for the Future." (Brown Report.) The entire program is based on the principle that a careful analysis of the problem must precede its solution.

The nursing organizations are to be congratulated upon their initiative and for their foresight in organizing for the ever increasing tasks which their profession is falling heir to, and which they have willingly accepted.

PROSPECTING FOR SCIENTIFIC GOLD

IT IS of great interest to find, at times, practicing physicians, presumably not part of an institutional research staff, who have enough scientific curiosity to think about their cases, to be led thus into a bit of clinical research, and finally to publish their findings. While such a "researcher" may not be able to *prove* anything, his suggestions, or inferences, taken together with those of similar workers elsewhere may be synthesized to produce definite results.

In the February 1950 number of *Annals of Western Medicine and Surgery*, a letter to the editor from L. L. Craven, M.D., of Glendale, California, comments on the anticoagulant effect of acetylsalicylic acid and suggests study of its use as a prophylactic agent in preventing thrombosis. He is especially interested in coronary thrombosis and states that

> During the past two years, I have advised all of my male patients between the ages of 40 and 65 to take from 10 to 30 grains of acetylsalicylic acid daily as a possible preventive of coronary thrombosis. More than 400 have done so, and of these, none has suffered a coronary thrombosis. From past experience, I should have expected at least a few thrombotic episodes among this group.

In *Minnesota Medicine* for October, 1950 we find R. L. Parsons, M.D., of Monterey, Minnesota, and J. J. Heimark, M.D., of Fairmont, Minnesota, collaborating on "The Prediction and Prevention of Coronary Thrombosis in the Younger Age Groups, A Suggestion for Further Study." They are particularly concerned with cases in the fourth, fifth and sixth decades, and aver:

> The factors causing a coronary complex in the people in these earlier decades differ markedly from those in the aged. In older people, the primary cause of this trouble is an extensive intimal damage in the coronary arterial tree. Secondary factors are sedentary life, improper diet, and probably disease. In the younger years this initial damage is usually only moderate to minor. Several other factors apparently combine in varying importance to cause an infarction. Among these are prolonged nervous tension, the prothrombin time level, diet, and smoking. It is generally conceded that coronary constriction from chronic over-stimulation due to high nervous tension, worry, and overwork plays an important role in the foregoing disease entity. Therefore, we shall not add further comment. However, it is different with the other factors mentioned.
>
> In the patients with coronary heart disease whom we have observed, we have been impressed by the low prothrombin time uniformly present. Likewise, we have been impressed by the fairly prompt relief of pain in the nonfatal cases when the prothrombin time has been quickly elevated by the use of the anticoagulants, heparin and dicumarol. We also noted that the pain did not often recur if the prothrombin time level was sustained at a sufficient height. Pain, however, was most likely to recur following a meal. Knowing of no explanation for this, we ran a short series of prothrombin time levels (Smith bedside whole blood method) on normal individuals immediately before eating and again an hour afterwards. The results are shown in Table I.

TABLE I. PROTHROMBIN TIME BEFORE AND AFTER MIXED MEAL

Name	Approx. Age	Before Meal (Seconds)	After Meal (1 Hour) (Seconds)
G.P.	24	60*	55
A.G.	55	75†	60
S.L.	22	90†	75
B.J.	19	70*	65
A.R.	24	70†	60

* Light meal
† Moderate to heavy meal

This further observation was made. If the patient was allowed to smoke cigarettes, he frequently was threatened with a syndromal attack. On suspicion, these few tests were run on normal people (Table III).

TABLE III. PROTHROMBIN TIME BEFORE AND AFTER SMOKING

Name	Approx. Age	Fasting 7 a.m. No Liquids (Seconds)	Fasting ½ Hour After smoking 2 Cigarettes (Seconds)
B.J.	19	60	45
C.T.	40	70	60
J.C.	40	45	35
G.A.	45	65	50
A.R.	24	60	45

From this meager evidence, it may be that cigarette-smoking acts not only to constrict the arterial lumen but, what may be more dangerous, to lower the prothrombin time level.

It is known, of course, that a high percentage of people subjected to these same conditions, tension, dietary indiscretions, and smoking, survive into an older age group. There must, then, be some common factor that determines the precipitation of coronary attacks at different ages. We believe this factor to be the difference in prothrombin time level. We believe that this difference in level is a hereditary factor, and that it plays an important rôle in coronary attacks. Therefore, we believe that coronary attacks are predictable and preventable.

Assuming, then, that this reasoning is correct, should it not be reasonable to assume that by routine testing, individuals prone to coronary disease could be detected and prophylactically treated with dicumarol to elevate the prothrombin time to a satisfactory and safe level just as the diabetic individual can be detected and treated?

We realize, of course, that a prolonged research would be required to establish the proof of this reasoning. Even a few hundred selected people tested and followed

through the years should establish the veracity of this contention. We believe, however, that such research in prothrombin time levels would be justified in an attempt to prevent the colossal cost in heart deaths exacted by our modern high-geared society.

It is true that these reports are based on clinical research on a small scale,—freely admitted by the authors. Yet these men have been thinking about their cases of coronary thrombosis and have done constructive work along the line of prophylaxis. Whether their methods and conclusions will stand up under further research is not so important as the fact that they have at least done more than mental wringing of the hands over a bad situation.

Without doubt there are many practitioners in Indiana who have done considerable thinking about their cases, of whatever sort, but who have remained inarticulate. Letters to the editor are one medium of expression, case reports another, both lending themselves to reporting individual ideas and experiences without elaborate work-up and bibliographic window-dressing. Grains of pollen are mighty small, but may fertilize one of Nature's larger projects many miles away. Besides, your letter-to-the-editor might easily be the saltiest reading matter in that issue. Don't deny your brother practitioners such pleasure, — and such stimulation—as they may obtain. You may have panned a nugget.

DOCTOR STRANGE HONORED

THE HOUSE OF DELEGATES of the A.M.A., at the Fourth Clinical Session in Cleveland, chose Dr. Dean Luce, of Canton, Massachusetts, as "General Practitioner of the Year."

Dr. John W. Strange, of Loogootee, Indiana's nominee for the award, was honored by being selected as one of the three candidates on which the final balloting took place.

The A.M.A., in reporting the event, named Dr. Jim Camp of Pecos, Texas, as the third nominee, and pointed out that inclusion in the list of three was in itself a signal honor.

This is the second time in the four-year history of the award that the Hoosier nominee has been included among the three doctors whose names are chosen from the complete list of candidates, and whose names are presented to the House of Delegates.

Doctor Strange is to be congratulated for so ably representing us this year.

Letters to the Editor

Members of the Indiana State Medical Association:

THE JOURNAL of the Indiana State Medical Association has done the members of the association a service by its publication of the nonscientific article "The Responsibility of the Hospital for the Educational Stimulation of the General Practitioner," by Sister Lydia of St. Vincent's. This is a fair statement by a hospital superintendent of the concepts behind the Acceptable Minimum Standards fallacy of the American College of Surgeons, and behind the apparent will of the American Hospital Association to control the hospitals of America.

The first paragraph that classes doctors as knowing "less and less about more and more," and its converse, passes backward through the pages of our lexicon from "levity" toward "impertinence." This quotation, out of context, ignores the contributions to the cultural aspects of American life that have sprung from doctors. Art, literature, law, music, military tactics, conservation, and the humanities are a few of the many fields in which doctors have made notable contributions. Yet it is Sister Lydia's "responsibility to consider the preparation of physicians."

There is too much obvious lack of understanding that is a matter of concern to doctors in Sister Lydia's article for each paragraph to be dissected here. One great injustice to members of the Indiana State Medical Association stands out. Now that "staff privileges" are to be extended to the lowly GP, "there must be no lowering of the standards. The alternative is to raise the qualifications of the GP."

It should be known, for instance, that the park system of Indianapolis came into being through the vision of a GP, a member of the Indianapolis Medical Society. In like manner there are few civic enterprises or cultural activities in Indianapolis that do not have GP members of our society as motivating actors in getting the jobs done for the benefit of the community.

In medical science it takes but a casual glance at the program record, or at the out-of-city and out-of-state lecture platforms to take the professional measure of our members. What has prepared Sister Lydia to add to this?

In the light of past performance and present activities of the members of the Indianapolis Medical Society I would recommend coming backward again in our dictionary to the word "humility." The Greatest Physician advised that virtue to all in places of responsibility.

In the entire article no proper thought is given to the voluntary open meetings that abound in all sections of the country every year. No thought is

given to preceptorship, formal or informal. No thought is given to the ever-present seeker of an answer who digs it out from near or remote practitioners and imparts his own original flavor to the result. Of these, medicine in America has grown to surpass all of its predecessors. From this benignant growth our hospitals have become popular workshops supported by all of us through tax advantage, tax exemptions, federal funds, and voluntary contributions.

To distort the function of the hospital away from service to the sick and into "teaching fields" is to ignore or deny American Medicine and its unique success. It is a blind, unthinking, and ungenerous move.

It is parallel, however, to an instance of the working of the "reorganization plan" of Sister Lydia at St. Vincent's. After ten months in that hospital as a totally and permanently disabled patient, Dr. Noble, Sr., was sent a form to fill out, to describe his preparation, internship, and record in medicine. If he returned this within a certain time, Sister Lydia would refer it to her committee on credentials and they would act on it. If accepted, he would be granted "courtesy membership." Signed by Sister Lydia.

This was the reward for more than fifty years of service to the sick of Indiana, without regard for race, religion, or pocketbook. This was the recognition by Sister Lydia for more than fifty years "use of the privileges" of St. Vincent's. I recommend turning the pages of the book even farther back. My father asked no "gratitude" or "favor," so it will be well to come farther back to a profound study of "compassion."

This year Sister Lydia heard a Jesuit Father expound at length on the rare privilege some of us have in our opportunities to serve unfortunate mankind. He described the obligations of good people toward the sick, from the admitting office through their stay and to their dismissal. He was an idealist, and more, had a powerful command of simple direct language. If his advice were followed we in Indianapolis would have none of this present disturbance.

Perhaps there is some value in the idea said to be openly expressed to several doctors, "I have given the Indianapolis Medical Society its worst licking." Perhaps that explains something.

But there can be no excuse or justification for any layman to try to remodel busy doctors into some new form of animal, and call that "raising the standards." All of this article shows a woeful, even unbelievable, lack of acquaintance with doctors, their professional, scientific, and cultural achievements—and their unique record of altruistic service to all men. I speak here, proudly, of the doctors of the Indiana State Medical Association, and of the Indianapolis Medical Society.

There are two words, finally, that I recommend for study to Sister Lydia as a research project. Any of many priests I know would be glad to define and explain the all-important first one—"Christian."

The recent election tells us that the average man in the street, who has a monetary interest in St. Vincent's, is quite capable of discussing the meaning of "American."

Thomas B. Noble, Jr., M.D., F.I.C.S., Diplomate International Board of Surgery, 1951 President Indiana Section International College of Surgeons, Anthropological and Medical Divisions American Association for the Advancement of Science, American Anthropological Association, American Society for Archeology, former chairman Section on Anthropology Indiana Academy of Science, Photographic Society of America, former President Indianapolis Camera Club, Indianapolis Literary Society, Indianapolis Service Club, etc., author "The Treatment of Peritonitis and Its Aftermath," contributor to abdominal surgery of more than twenty original methods, techniques, or bits of research. Kindly excuse the aroused and stimulated bombast.

Dear Doctor:

I am writing to extend a cordial invitation to members of the Indiana State Medical Association to attend a three-day Sectional Meeting of the American College of Surgeons in St. Louis on January 22, 23 and 24. The Statler Hotel will be Headquarters for the meeting and requests for hotel accommodations should be directed to the Statler Hotel in St. Louis.

The program for this meeting will include new surgical motion pictures, a special program on trauma, a cancer symposium, and panels or papers on Vascular Surgery, Chest Injuries, Fractures about the Ankle Joint, Hematuria following Trauma, Neck Surgery, Osteomyelitis, Ulcerative Colitis, Cancer of the Stomach, and Emergencies Arising During Operation. The first two days of the program will be presented at the Headquarters Hotel and on January 24 the hospitals in St. Louis will offer a full day of surgical clinics for those in attendance at the meeting.

A five-dollar registration fee will be required, except from Fellows and members of the Junior and Senior Candidate Groups of the College, and interns and residents, but we are confident that the physician or surgeon in practice will find the program worth many times the registration fee.

As Chairman of the Committee on Arrangements I can assure you that the Fellows of the College in St. Louis will give full cooperation in assisting members of the Indiana State Medical Association to take full advantage of this excellent meeting if they will come to St. Louis on January 22, 23 and 24.

Sincerely yours,

James Barrett Brown, M.D., Chairman,
Committee on Arrangements

President's Page

PATIENT AND PERSISTENT PEOPLE

AS THIS is being written the heart of every American is heavy. The news of our military catastrophe in the bitter cold of North Korea sobers and saddens us. The Red Hordes, which were obviously planned for and organized months or perhaps years ago, are slaughtering our sons, who may wonder for what they are fighting. Our leadership, in the past several years, has led us down some grievous and disastrous paths. Is our apathy so great that these recent events will not bring the bitter truth into realization?

The elections of November 7 were heartening to every real American, in that they indicated that at long last a greater number of our people are beginning to think for themselves. The Planners and their Allies have been so successful with their formulas of class hatred, something-for-nothing, racial prejudice, deficit financing, etc., that most of us had despaired of a return to sanity and integrity in Washington. It would now seem that there is some ray of hope for those who want a solvent America and the freedoms and liberties which the Constitution and Bill of Rights would provide for us.

But let me emphasize to you that these Planners are patient and persistent people and that they are cunning and shrewd to an incredible degree. Public sentiment recently would seem to indicate that the passage of a national compulsory health tax scheme is improbable in the near future. Realizing this, the Planners have adopted a new course. Their success, so far, is indicated by the fact that they have already brought about a new form of socialization involving the medical profession, namely, a compulsory tax for cash sickness benefits in 8 percent of our nation, or in other words, four of our states, New Jersey, Rhode Island, New York and California.

Yes, the Planners are patient and persistent people. And cunning and shrewd, too.

☆ ☆ ☆ ☆ ☆

HAPPY NEW YEAR TO YOU

Happiness, you know, is not found in Florida, or on the cool Minnesota lake in the summer or on the lovely cruise around the world—real happiness is found inside ourselves. May your New Year be interesting and worthwhile, and may it bring to you this real happiness.

Alfred Edison

Medical Panorama by the Associate Editor

Dr. Hawley: On Medical Care in the U. S.

On September 12, 1950, Dr. Paul R. Hawley, Director, American College of Surgeons, spoke on "The Doctor and the Social Revolution" at New Haven, and his paper is published in the *Connecticut State Medical Journal* for November. It is an interesting and cogent address, and while some of his remarks on insurance, as will be seen below, are contrary to the majority opinion expressed at the last meeting of our House of Delegates, nevertheless we must keep in contact with ideas and abreast of projects in medicine beyond our borders. Hence, several quotes follow:

The very first thing the medical profession should do to save itself in this social revolution is to examine the criticisms of present-day medical practice in a detached, impartial and objective manner. To such as have merit, we must adjust if we are to survive. Those that are without foundation must be shown to be false—but the manner of proving their falsity must be convincing and not tinged with the stigma of selfish propaganda.

One of the stock charges made against the present system of medical care is that there are hundreds of thousands of people in this country suffering and dying each year because they are unable to afford adequate medical care. . . .

It is a very simple matter to prove or disprove this charge. All that is necessary is for the doctors of a community to agree that no one in their community shall go without necessary medical care solely because they are unable to pay for it. . . .

I know of no greater contribution the profession can make—can make to the public, can make in its own interest, if we must be selfish—than to inaugurate and conscientiously promote such a program. Obviously the profession must be protected against abuses; but social service is so well developed in the larger centers, and everyone is so well known in small communities, that determination of ability to pay should not be difficult. . . .

A suggestion as to fees:

Complaints against excessive fees arise only in cases where there has been no discussion of the fee beforehand. More and more surgeons, in particular, are now arranging their fees prior to undertaking the care of the case; and none, who has tried this practice, would return to the old system of blind fees after the operation. . . .

And now about service benefits in Blue Shield Plans:

The application of service benefits in Blue Shield Plans has caused some problems and is still the topic of heated arguments among doctors. I might say that, upon principle, I am opposed to the rigid fixing of fees. However, the practice of medicine is now in a position where, if we insist upon every advantage, we shall lose everything. The majority of the public are completely sold upon the service benefit principle for the low income group; and I am fully convinced that the medical profession must make this concession or we shall be forced into a much worse position. . . .

Some method of prepayment of the costs of medical care is one development of our social revolution which is here to stay. Upon our full adjustment to, and guidance of this innovation depends the continued freedom of medical practice. I do not for one moment think that health insurance is at present a perfect institution either for the patient or the doctor; but I do believe that it can be developed into a blessing for the doctor as well as for the patient. It will work profound changes in medical economics, it is true; but we must be prepared to accept changes or we shall have changes forced upon us which will be much more distasteful.

For its own salvation, to prevent complete disaster, the medical profession must recognize the existence of this revolution and must adjust to it. We must examine ourselves critically and weed out both practices and practitioners that are inimical to the public interest. And, lastly, we must try conscientiously to support the practical efforts that are being made to maintain the freedom of medical practice.

We have the choice only between two courses—with our feet firmly planted upon the great traditions of medicine, we can sway with the storms that beat upon us . . . or we can stand rigidly and unyieldingly upon our selfish interests and be broken against the wall of public opinion.

The question still is: how much shall we sway?

"DOWN THE DRAIN"
Health Service Waste

In 1949, the staggering total of 201,000,000 prescriptions was dispensed for National Health Service Patients in England and Wales (population approximately 40,000,000).

One prescription in every three was for a mixture—nearly 70,000,000 bottles—which works out to at least half a pint per head of the population.

Wrote the Health Ministry's Chief Pharmacist Davis in the recent Education Number of the "Medical Press": "I have seen National Health Service prescriptions for Winchester quarts of mixtures which were never designed to be kept for more than a few days.

"Visible signs of deterioration would soon be evident, and the greater proportion of the mixture discarded."

Commented the "Medical Press" last week: "We have to face the fact that, for whatever reason, the medicine habit has taken such solid root that nine patients out of ten expect a prescription and feel that they are not receiving their due if none is forthcoming.

"Until a sense of responsibility is developed, Winchester quarts of toilsomely compounded medicines will continue to enrich our drains."

—*The Recorder*, (London, England)

PROGRAM

CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

Riley Room, Claypool Hotel

INDIANAPOLIS

SUNDAY, JANUARY 28, 1951

9:30-10:00 A.M.	Registration
10:00-10:10 A.M.	Introduction of President A. M. MITCHELL, M.D., *Chairman* Address of Welcome— ALFRED ELLISON, M.D., *President I.S.M.A.*
10:10-10:40 A.M.	"The Status of Mental Health and Mental Hygiene Societies"— E. VERNON HAHN, M.D.
10:40-11:10 A.M.	"Medical Fees"—DAVIS W. ELLIS, M.D.
11:10-11:30 A.M.	Discussion
11:30-12:00 M.	"The County Societies' Responsibilities in the Organization and Operation of the Civilian Defense Program"— GLEN WARD LEE, M.D.
12:00- 1:30 P.M.	Luncheon ($2.25 per plate including waiters gratuity.) "The Role of the Individual Physician in His Community"— JOHN F. CONLON, M.D., *Director of Medical Information and Education, Massachusetts Medical Society.*
1:30- 2:00 P.M.	"Human Relations Within the Society"—C. J. CLARK, M.D.
2:00- 2:30 P.M.	"The Society's Responsibility in its Community Health" "Plans for Improving Rural Health"—LOUIS E. HOW, M.D. "Plans for Better School Health"—G. O. LARSON, M.D.
2:30- 2:50 P.M.	"The Legislative Picture" "The National Scene"—DONALD E. WOOD, M.D., *Co-chairman, Committee on Public Policy and Legislation.* "The State Picture"—NORMAN R. BOOHER, M.D., *Co-chairman, Committee on Public Policy and Legislation.*
2:50- 3:00 P.M.	Report on National Public Relations Conference— EARL W. MERICLE, M.D.
3:00- 3:30 P.M.	Discussion
3:30	Election of Officers Adjournment.

LUNCHEON RESERVATION

Dr. A. M. Mitchell, Chairman
Conference of County Medical Society Officers
1021 Hume Mansur Building
Indianapolis 4, Indiana

Please reserve ..... places for me at the Conference of County Medical Society Officers' luncheon at the Claypool Hotel, Indianapolis, at 12:00 P.M., Sunday, January 28, 1951.

.....M.D.

.....City

Please Tear Off and Mail Before January 23, 1951

Claypool Hotel requires luncheon reservations in advance

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

FEWER MEDICS FOR THE ARMY

The armed services are reaching out for doctors again, as they did desperately in World War II. They will need a lot of them, to serve the expanded military forces, but this time the army at least is showing better judgment in calling them.

In the last war the services took 40 percent of our medical men to take care of the 7 percent of the population that was in uniform. That was done despite the assertion that the average soldier needs less medical attention than the average civilian, including the extra requirements of combat.

On that basis there was a tremendous waste of doctor-power in the services. Most doctors who were in uniform can relate tales of the waste, stories of highly trained men who were given minor assignments or jobs which really didn't call for medical men at all.

The army used to keep about 70 doctors with a division whether it was in combat or not. Now it's going to give more jobs to trained enlisted personnel. As a result, a division will need about three doctors for ordinary sick call and 42 when in combat. In military hospitals, doctors will be given a minimum amount of administrative duty, and field and evacuation hospitals will be built up to full doctor strength only when they get into actual operation.

The policy being followed in the Korean war also is reducing the army's need for doctors. Wounded are being flown back to the United States for treatment whenever possible. Fewer doctors in hospitals here can do the work of many doctors overseas, and the men will get better attention. Further, the plan saves the doctors' time one way on hospital ships.

Though the average civilian needs more medical care than the man in uniform, the proportion of doctors must be higher for the military services. Geography is one big reason. Small segments of the armed forces are scattered all over the world, but medical services must be available for them wherever they are.

The present goal of putting 1.6 percent of our population in uniform would take only about 8 percent of the medical men. That's a lot better average than in World War II. However, the navy and marine corps haven't come along on the army's plan. The marines still want 70 doctors to a division, and the navy insists on doctors as administrative heads of hospitals.

—*The Gary Post-Tribune.*

POLITICAL MEDICINE vs. FREE MEDICINE

The British ministry of health reports that the year ending March 31, 1949, was Britain's best year in terms of good health. It was the first year in which socialized medicine was operative in Britain.

The death rate in Britain was 10.8 in 1,000. The infant mortality rate was 34 in 1,000.

The United States, where medicine is a free profession, despite the efforts of the Truman administration to bring it under state control, had a death rate of 9.9 for each 1,000 population in 1948, the last year for which statistics are available. The infant mortality rate for 1948 was 32 in 1,000 babies in their first year of life. Our showing in both of these categories was better than Britain's.

Oscar Ewing, the federal security administrator, who is the chief administration proponent of political medicine, came back from England a few months ago praising British socialized medicine to the skies. If that system is better for everybody, why do the figures show the contrary?—*Chicago Tribune.*

SO WHAT?

One of the federal officials trying to persuade congress to approve the so-called national health insurance project offers a peculiar argument in attempting to refute the charge that it is a socialistic or communistic scheme. "Is insurance," he inquires rhetorically, "such a revolutionary idea? Does automobile insurance smack of Karl Marx?" He chooses to ignore the fact that up to now government compulsion has not been used to convince Americans that insurance is desirable.

In ever-increasing numbers Americans have been voluntarily contracting not only for the automobile insurance that the official mentions but for various other types. At present the voluntary health insurance movement is expanding rapidly. The difference between voluntary insurance and government-imposed insurance is vast and radical. Thus the official's intimation that compulsory health insurance would not be socialistic or Marxian because private, voluntary insurance is not socialistic insults Americans' intelligence.

—South Bend *Tribune*

SOCIALIZED MEDICINE IS NO BARGAIN*

WILLIAM L. HUTCHESON

GENERAL PRESIDENT, UNITED BROTHERHOOD OF CARPENTERS & JOINERS OF AMERICA AND VICE PRESIDENT OF THE AMERICAN FEDERATION OF LABOR

I AM AGAINST socialized medicine. So is the organization which I have the honor of heading. At the Twenty-sixth General Convention of the United Brotherhood of Carpenters and Joiners of America, held in Cincinnati last September 1, 300 delegates, representing better than 54 percent of the total membership, voted down a resolution to support the National Health Program. This probably does not jibe with the feelings of a good deal of the rest of the labor movement because much of the pressure for "free" medical care is coming from labor organizations. But it does reflect my sentiments and the sentiments of our recent convention.

Saving a dollar has never been distasteful to me. In fact I like to get as much for my money as the next man. That is one of the reasons why I oppose socialized medicine. It is no bargain. It looks cheap the way the backers present it, but when you dig down under the fancy layer of propaganda frosting you find that it can be mighty expensive. The British people have already discovered this fact. The July issue of *International Labour Office* contains some very interesting data on the operation of the National Health Service in Britain. I quote a few lines of that report:

"The total (gross) cost of the National Health Service in 1948-1949, the first year of operation, greatly exceeded the original estimate. This was 265 million pounds, as against a revised estimate of 368 million pounds, with a net cost to the taxpayer of 278 million pounds. The revised estimate for the year 1949-1950 was 450 million pounds as against an original estimate of 352 million pounds. For the year 1950-1951, the cost is estimated at 484 million pounds; in 1946 when the Bill was passed, the service was believed to cost 167 million pounds a year."

In case you don't understand what the International Labour Office is, I can best explain its functions by quoting a bit from its preamble:

"The International Labour Office is an association of nations, financed by Governments and democratically controlled by representatives of Governments, of management and of Labour organizations.

"Its purpose is to promote social justice in all countries of the world. To this end it collects facts about labour and social conditions, formulates minimum international standards, and supervises their national application."

The I.L.O.'s publication, *International Labour Review*, is published in the United Kingdom. As an international organization, I.L.O.'s findings are supposed to be strictly impartial.

Getting back to the report; if I read it correctly, service that was supposed to cost 167 million pounds per year when the plan was set up in 1946 costs 484 million pounds per year, and the end is not yet in sight. By my old-fashioned kind of arithmetic that is an increase of better than 345 percent and I am sure my poor old mother, who always made a dime do the work of a quarter, would not consider that kind of proposition any bargain.

I know! I know! The socialists claim that money is of no consequence in the matter of national health;—getting the poor the same quality and quantity of medical care as the rich can get under private enterprise is the advertised objective of the National Health Program. That sounds fine, too; but on Page 57 of the I.L.O. report, I find the following sentences:

"Survey of the distribution of doctors by boroughs shows that certain wealthier districts (of London) have an average of one doctor for 1,261 patients, while in the inner East End there are 2,472, or twice as many patients, per doctor. For a group of southern boroughs, the average is 2,897."

If that isn't the "one horse and one rabbit" recipe transferred from the meat pie maker's kitchen to the National Health program, then I need new reading glasses. I have tried to figure it from all angles but the answer I always come up with is that the lumbago, shingles and bellyaches of London's South Siders get only half the attention that similar ailments get in the swankier districts. For all the planning that has been done, there is still an uneven distribution of doctors in London. If the backers of the National Health Program are to achieve their objective of equal health protection for all, the next step must be to tell doctors when and where and how they are to practice. Therein lies my greatest fear of socialization.

Socialization and death have one thing in common; you cannot be either a little bit socialized or a little bit dead. It is whole hog or nothing. After two years of the National Health Program, London doctors still have preferences as to where they want to practice. By compulsion of one kind

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or another, somebody is going to have to shoo doctors away from the fancy neighborhoods into the tenement districts or the program will wind up where it started. When the government is given authority to tell one group or one profession where and how its members are to work, no other group or profession can be safe for long.

If the day ever comes to America when Uncle Sam usurps the power to dictate to doctors under a health plan, it will be a sad day for carpenters. Adequate housing is still an unsolved problem in this country, especially for the poor. If it is logical to nationalize the medical profession to get more medical service for the poor, it is equally logical to nationalize the home construction industry to get roofs over the heads of the lower income groups.

I do not know much about doctors, but I know quite a bit about carpenters. They are an independent lot. They want to work where and how they please. The first bureaucrat who told a carpenter he had to work in Little Rock when he wanted to work in Lancaster would be gumming his food for lack of teeth. Carpenters want to be free agents; free to work where they want to; free to negotiate the terms of their wages and working conditions through collective bargaining; yes, even free to leave the industry and try their luck at something else if the spirit moves them.

They will retain these freedoms only so long as all other groups retain theirs. Socialization is like a wolf with a tapeworm; once it starts gnawing, it never can stop. Socialized medicine would only be the first bite out of our free enterprise system; it would not be many years before the carpenters would be feeling the teeth of socialization on the seats of their overalls. Any way you look at it, socialized medicine is no bargain and the carpenters want none of it.

I know that the backers of the national health plan in this country resent the term "socialized medicine." They have all sorts of arguments to "prove" that doctors and patients will remain free as the air under their program. They make a strong case. Perhaps if human nature were less ornery and less avaricious, an idealistic health program might work out all right. But so long as people have preferences, so long as Park Avenue has more appeal than Hell's Kitchen, there will be an uneven distribution of doctors under any plan that does not contain compulsion. And once compulsion enters the picture, the rights and freedoms of all citizens stand in jeopardy. To me, it is as simple as that. For forty years I have fought communism tooth and toenail because I do not want anyone pushing me around. I certainly do not want to put my head into a socialization noose voluntarily when the results can be as undesirable as communism.

I have always respected the medical profession for the fine contribution American medicine has made to human welfare. As I watched your battle against regimentation during the past two years, I have added to that respect. The physicians of this country have shown that they are willing to fight for their conviction. I salute you today not only as doctors but as crusading citizens as well. We in the labor movement have our own cross of regimentation to bear. The fight you are making is part of the same war. It is a war against concentration of authority in a few hands in Washington. As a veteran of forty years in the labor movement, I know what it is to fight for human rights. I am happy to take my stand beside you.

ACTH, CORTISONE REDUCE CANCER PAIN BUT DON'T STOP DISEASE

Evidence gained in a study of far advanced cancer patients by three Chicago doctors indicates that treatment with ACTH and cortisone is helpful in reducing the pain and other complications of the disease but does not materially alter the natural course of the disease. Drs. Samuel G. Taylor, III, John P. Ayer and Roger S. Morris, Jr., reported on their study of 26 advanced cancer patients in the November 25 *Journal of the American Medical Association*. All three doctors are associated with the Presbyterian Hospital, Chicago. The report says in part:

"The clinical response of most patients was reduction in fever, if present, increased appetite and improved strength and well-being. At times the effect were dramatic and appeared usually within 48 hours after ACTH therapy and within four to six days after starting treatment with cortisone.

"Patients hitherto bedridden, vomiting and requiring heavy doses of narcotics were able to become ambulatory, reduce or stop their reliance on narcotics, and eat astonishing meals."

According to the report, however, the "improved" condition of the patients was only temporary. The natural course of the disease continued—12 of the patients already have died. In addition, the hormone treatment produced disturbing side effects.

"We have frequently been faced with the problem," the doctors explained, "whether complications produced by continued therapy or relapse from omission caused more distress to the patient."

Some of the side effects produced by ACTH and cortisone which, according to the doctors, may make "repeated or prolonged therapy ill advised" were chemical changes in the body, excess sugar in the blood, mental and personality changes, sexual and skin disturbances, development of moon-shaped faces and unnatural fat deposits in different parts of the body.

FEDERAL INCOME TAX AND THE MEDICAL PROFESSION

RALPH W. CRIPE
Collector of Internal Revenue
INDIANAPOLIS

THE REVENUE ACT of 1950, approved September 23, 1950, as a revenue-raising measure, did not change the $600.00 exemption allowance; neither did it change the surtax or normal tax rates. There is no change in the method of computation until after determination of the tentative tax. However, the new law increases the taxpayer's liability by decreasing the percentage of reduction in tentative tax. Under prior law the following reduction of tentative tax was used:

(a) Not over $400.00, 17 percent of tentative tax.
(b) Over $400.00 but not over $100,000.00, $68.00 plus 12 percent of the excess over $400.00 of tentative tax.
(c) Over $100,000.00, $12,020.00 plus 9.75 percent of the excess over $100,000.00 of tentative tax.

The revised reduction of tentative tax for the calendar year 1950 is as follows:

(a) Not over $400.00, 13 percent of tentative tax.
(b) Over $400.00 but not over $100,000.00, $52.00 plus 9 percent of the excess over $400.00 of tentative tax.
(c) Over $100,000.00, $9,016.00 plus 7.3 percent of the excess over $100,000.00 of tentative tax.

The Revenue Act of 1950 entirely eliminates the reduction in tentative tax for taxable years beginning on or after October 1, 1950.

As in 1949, married taxpayers can file jointly and include all the exemptions, income and deductions of both husband and wife. Even though one spouse had no income, husband and wife may still file a joint return. Such a filing is always to the taxpayers' advantage if the income of one spouse is less than $600.00. Attention is especially directed to the fact that a spouse is not in the same category as a dependent, in that it is necessary to include the spouse's income in a joint return even though the income of the spouse is less than $600.00; otherwise it will be necessary to eliminate the exemption for such spouse.

All married taxpayers who file joint returns can still split their income in computing their income tax, as under prior law. Ordinarily it will be advantageous for married couples to file joint returns using the "split-income" method of computing the tax. It usually results in a lower tax than would result from the use of separate returns. This is because the tax is computed at the surtax rates which apply to each half of the income. The surtax on one-half of the taxable income when multiplied by two results in a total tax considerably less than if it had been computed on the total income as one sum. It is the reduction in the applicable surtax rate which results in a total tax reduction.

If a joint return is filed, both spouses must sign it. By so doing, each assumes full legal responsibility for the entire tax.

A taxpayer is entitled to only one $600.00 exemption for each dependent. The law puts very exact limitations on who is a dependent. Each dependent must meet all four of the following tests:

1. He or she received over one-half of his or her support from you in 1950, and
2. He or she was "closely related" to you, and
3. He or she did not have $500.00 or more gross income of his or her own in 1950, and
4. If married, her or his exemption is not claimed on the return of her husband or his wife.

To qualify as a dependent, a person must also be either a citizen of the United States, or a resident of the United States, Canada, or Mexico. "Closely related" means:

(a) Your child (including a legally-adopted child) or his or her descendant.
(b) A stepchild (but not his or her descendant).
(c) A brother or sister (including a half-brother or half-sister), a stepbrother, or a stepsister. Half-brothers have one parent in common, as the same mother and different fathers, or the same father and different mothers; stepbrothers, however, were born into different families, and are related only because the father of one subsequently married the mother of the other.
(d) Your parent, grandparent or other ancestor.
(e) Your stepfather or stepmother.
(f) Your uncle, aunt, nephew, or niece, but not their husbands or wives. No provision is made for your cousins.
(g) Your "in-laws" — father-in-law, mother-in-law. brother-in-law, sister-in-law, son-in-law, or daughter-in-law.

An exemption for a dependent can be allowed to only one taxpayer and that taxpayer must have furnished more than one-half of the total cost of the dependent's support for the year. The term, "support," speaking generally, includes board, lodging, clothing, medical and dental care, cost of education, and expenses of similar character. Where during the taxable year a dependent has received support from several sources, each source is regarded as contributing pro rata to his support.

The taxpayer who desires to claim an exemption on account of such a dependent should ascertain the total cost of the latter's support during the year; in order to qualify for the exemption, the taxpayer must have furnished more than one-half of the actual cost of that support.

A written record of receipts and expenditures is highly important. A taxpayer's regular accounts, files of receipts, and usual records should be sufficient for filing income tax returns, provided that actual and complete information is available and the taxpayer is prepared to prove the essential reality of claims or statements made. The importance of maintaining adequate records of income and expenses cannot be overemphasized.

The statutory net profit from a medical profession engaged in individually is recorded in Schedule C of Form 1040, which for the year 1950 is a separate schedule supplementary to Form 1040. The net profit determined in the supplementary Schedule C should be carried over to Schedule C, page 2 of Form 1040. The entire amount of income derived from such profession should be reported. This point also cannot be overemphasized. Professional men incur ordinary and necessary business expenses which should be listed in Schedule C. These include the maintenance and repair of an automobile which is used for his professional purposes, or for that portion of the use of his private automobile which is applicable to his profession. Similarly, membership in professional societies, subscriptions to technical journals and current magazines used in the reception room of his office, as well as fees paid to other professional men for professional assistance, are deductible.

Some professional men combine their residences with their offices. In such cases, a professional man may deduct that part of the expense incurred for heat, electricity, etc., which is directly attributable to his profession. Professional men may not, however, deduct the cost of books, instruments, and equipment having a useful life longer than a year. These are regarded as capital items, and depreciation may be taken on them over the life of the equipment.

Similarly, equipment or other necessities of his profession which are replaced or improved are regarded as capital expenditures, and are not deductible.

The reason capital expenditures are not deductible is that they are not operating expenses applicable solely to the taxable year in which they are made. These expenditures may increase the value of property, or they may appreciably prolong the life of assets. Thus, they are to be depreciated over a period of years rather than deducted in any one taxable year.

If the final Form 1040 for the year 1950 is filed on or before January 15, 1951, and the tax as shown due is paid in full, the taxpayer is relieved of filing an amended declaration of estimated income tax, which might otherwise be required on that date. January 15, 1951, is also the due date for paying the fourth installment of the 1950 estimated income tax for a calendar-year taxpayer. The due date for filing the final 1950 return for an individual taxpayer on the calendar year basis is March 15, 1951. The payment accompanying the final return must cover the full amount not previously paid in connection with the declaration of estimated tax or through withholding.

On or before March 15, 1951, an individual deriving his income from the medical profession is required to file a declaration of estimated income tax for the year 1951 and pay at least one-fourth of the estimated tax at that time, if he is reporting on the calendar year basis.

For failing to file declaration or failing to pay estimated tax, the following penalties are imposed by law:—5 percent of the unpaid amount of each installment due, plus 1 percent for each month or part of a month (except the first) during which such amount remains unpaid, up to a maximum of 10 percent of the unpaid amount of such installment. For underestimating tax by more than 20 percent (33⅓ percent for farmers)—6 percent of the entire shortage in estimate, but not more than the amount by which the estimate falls short of 80 percent of the tax (or, in the case of farmers, 66⅔ percent of the tax). This penalty will not apply if the estimated tax for 1950 is computed on the basis of your 1949 income and your 1950 exemptions, and is paid on time in equal installments or is paid ahead of time (or, in the case of farmers, is paid in full on or before January 15, 1951).

Penalties provided for willful failure to make a return or for willfully making a false return are likewise applicable to declarations.

It is suggested that if any specific question arises relative to the determination of the Federal income tax you communicate with the Collector's Office, Post Office and Court House Building, Indianapolis, or contact the nearest zone or division office in Indiana.

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VIGO	Jack J. O'Grady (D) 2225 Crawford St., Terre Haute Leonard F. Conrad (D) 1522 Third Ave., Terre Haute	Richard James Cronin (D) 626 S. 6th St., Terre Haute Walter H. Maehling (D) 2206 N. 11th St., Terre Haute John F. Ryan (D) 1227 S. 9th St., Terre Haute
WABASH	Floyd Stevens (R) R.R. 2, Claypool	Herman D. Hartman (R) 426 N. Cass St., Wabash
WARREN	Wesley Malone (R) 1429 N. 8th St., Clinton	Cable G. Ball (R) 402 S. 9th St., Lafayette
WARRICK	Jack A. Stone (R) 916 S.E. 2nd St., Evansville	Addison M. Beavers (D) 121 Hargrave St., Boonville
WASHINGTON	John Blunt (D) Little York	James D. Allen (R) RFD 4, Salem

Counties	*Senators*	*Representatives*
WAYNE	Clem McConaha (R) R.R. 1, Centerville	Lothair Teetor (R) RFD 2, Hagerstown John M. Harlan (R) 3112 S.E. Parkway, Richmond
WELLS	Von A. Eichhorn (D) Box 57, Uniondale	Remy Bierly (D) 110 S. 3rd St., Decatur
WHITE	Roy Conrad (R) R.R. 2, Monticello	Glenn R. Slenker (R) 602 W. Broadway, Monticello
WHITLEY	Carl J. Moldenhauer (R) R. 7, Huntington	Richard B. Fishering (R) 1018 Kinnaird St., Ft. Wayne

INDIANA DELEGATION IN CONGRESS

United States Senators

Senior Senator. Hon. Homer E. Capehart (R)
Washington, Indiana

Junior Senator. Hon. William E. Jenner (R)
Bedford, Indiana

(Mail sent to them at Washington, D. C., should be addressed to Senate Office Building)

United States Representatives

First District. Hon. Ray J. Madden (D)
578 Broadway, Gary

Second District. Hon. Charles A. Halleck (R)
Rensselaer

Third District. Hon. Shepard J. Crumpacker (R)
1906 Bergan, South Bend

Fourth District. Hon. E. Ross Adair (R)
1925 Lincoln Tower, Ft. Wayne

Fifth District. Hon. John V. Beamer (R)
413 N. Miami, Wabash

Sixth District. Mrs. Cecil M. Harden (R)
Fifth and Liberty Sts., Covington

Seventh District. Hon. William Bray (R)
Martinsville

Eighth District. Hon. Winfield K. Denton (D)
957 E. Powell Ave., Evansville

Ninth District. Hon. Earl Wilson (R)
Bedford

Tenth District. Hon. Ralph Harvey (R)
R. R. 4, New Castle

Eleventh District Hon Charles B. Brownson (R)
127 E. Washington St., Indpls. 4

(Mail sent to them at Washington, D. C., should be addressed to House Office Building)

REPORT ON CLEVELAND MEETINGS

F. S. Crockett, M.D.*

LAFAYETTE

DETERMINED to prove that "actions speak louder than words" the House of Delegates of the A.M.A. overwhelmingly approved the recommendation of the Board of Trustees for the appropriation of one-half million dollars of association funds for aid to needy medical schools. On the following day it was announced that some $20,000 additional in gifts had been pledged to the fund, much of it from physicians attending the meeting.

President Elmer L. Henderson said, "The medical profession must take the initiative in raising private financing for hardpressed medical schools, rather than seeking federal subsidies for medical education."

In making the announcement to the House of Delegates, Dr. Louis E. Bauer, chairman of the Board of Trustees, stated, "We are pleased to announce that we have appropriated one-half million dollars out of our National Education Campaign Fund, which was raised to defend medical freedom, for the aid and support of medical schools which are in need of additional financing.

"This fund will be given to the medical schools for their unrestricted use in their basic training of future physicians. . . . The Board of Trustees, therefore, feels that it is keeping faith with the American people, who have given medicine such a splendid vote of confidence, when it contributes this amount to the medical schools of the Nation. . . .

"The Board hopes that this action will become a stimulus to other professions, industries, businesses, labor groups and private donors to contribute to this very important cause of protecting and advancing the interest of medical education and the public health."

Sunday and Monday, December 3 and 4, were devoted to a Public Relations meeting, with the first meeting of the Clinical session being held on Tuesday, December 5. Mr. Arthur Tiernan, executive secretary of the Vanderburgh County Medical Society, was on the Public Relations program. He discussed Vanderburgh County's plan of providing medical care for indigents.

The first order of business of the House of Delegates was the selection of the General Practitioner of the year. Indiana's Dr. John William Strange of Loogootee, who was named the General Practitioner of the year for Indiana, was one of the three candidates selected by the A.M.A. Committee of the Board of Trustees from all other candidates from the 48 states. In the final vote Dr. Dean Sherwood Luce of Canton, Massachusetts, was named the GP of the year by the House.

OTHER ACTIONS OF THE HOUSE

Quality of Medical Care in a National Health Program (Recommendations of the Subcommittee on Medical Care of American Public Health Association). The San Francisco session requested the Secretary and General Manager of the A.M.A. to communicate with the A.P.H.A. to determine if the recommendations of its Subcommittee on the Quality of Medical Care, in the report on the Quality of Medical Care in a National Health Program, were approved by the A.P.H.A. It was reported that their reply stated that this report had not been officially approved by the A.P.H.A. but was published merely for the purpose of study by its committees and subcommittees.

Resolution on Appropriations for Expenses of Section Delegates. The House approved the action of the Board of Trustees in denying the payment of expenses of Delegates of the various sections.

Resolution on Costs of Medical Care. This matter, referred to the Board of Trustees at the San Francisco meeting, requesting a study "which will result in educating the American people as to the differentiation between the costs of physicians' services and the cost of hospital services in hospitalized illness," has been fulfilled in intent, but the public education program has not been carried out as yet.

Resolution on Multiplicity of Meetings of Councils of A.M.A. In carrying out this resolution, the Board stated that it had cautioned all councils and committees on not calling meetings unless absolutely necessary, and that meetings were now being coordinated through the office of the Secretary and General Manager.

Resolution on Pilot Survey of Practitioners of So-Called Healing Arts. The House approved the action of the Board in referring this matter to the Bureau of Medical Economic Research.

Resolution on Medical Care of Civilian Employees of Armed Forces. The House approved the report that the Board had transmitted this resolution in several communications to the various departments concerned in Washington, in accordance with the sense of the resolution.

Resolution on Council on Federal Medical Services. This resolution introduced at the June meeting called for the establishment and financing by the A.M.A. of a standing committee to be known as "Council on Federal Medical Services." The new Council was to have the responsibility of "advising the Board of Trustees on all aspects of the several forms of federally supplied medical care, either now or to be established."

* Delegate from the Indiana State Medical Association to the House of Delegates of the American Medical Association.

The House approved the action of the Board of Trustees in referring this to the present Council on Medical Service and its Committee on Medical Care of Veterans, with the suggestion that the committee's name be expanded to include federal personnel.

Twelve Point Program. The House approved the appointment of Dr. Walter B. Martin, chairman, Dr. Edwin S. Hamilton and Dr. Leonard W. Larson to carry on a continuing study of the twelve-point program and to keep the Board advised of recommended changes from time to time.

Resolution from Section on Diseases of the Chest, on Tuberculosis Among Indians. Approval was given of the report in which it was stated that it was felt the time was not advisable for action on this matter due to the unsettled condition of the world.

Student American Medical Association: In accordance with action at the June meeting, steps have been taken to organize a Student American Medical Association. Letters have been sent to all medical school deans, calling attention to this plan, and many replies have been received. Contacts have been made with several of the schools, and plans call for the holding of a constitutional meeting at the headquarters of the A.M.A. on December 28, 1950, for the purpose of organizing such an association.

Report of the Washington Office of the A.M.A.: It was pointed out that the Washington office has grown in size and activity and that several bills approved by the A.M.A. have been enacted into law. It was also pointed out that as yet not one bill which was opposed by the A.M.A. has been enacted into law.

Council on Emergency Medical Service: Several matters of importance were presented to the House by the Council. Approved was the request that credit be given under Public Law 510, to reserve officers of the military participating in giving physical examinations for military service.

Civil Defense: The report on civil defense by the committee was commented upon widely and it was agreed that there has been too much delay in establishing adequate medical civil defense. The House strongly urged each state and component society to organize completely its medical civil defense system without further delay, that physicians be active at all levels of the civil defense program, and that additional space be allotted in the Journals for discussion of civil defense matters. It was reported, following the action of the House, that an Office of Medical Services, headed by a civilian physician, has been established by the Office of the Secretary of Defense. It was also reported that an advisory committee, which included two members of the A.M.A. Council on National Emergency Medical Care, has been appointed to advise the chairman of the National Security Resources Board at the topmost level of government, which in turn advises the President concerning the coordination of all military, industrial and civilian mobilization.

Report of the Committee on Blood Banks: The House recommended that a Committee on Blood Banks be established by each state and that they enlist the full support of all agencies. This, it was felt, would be the better way of establishing a system of blood banks that would more nearly meet the requirements of the individual states.

Establishment of Section on Military Medicine: The House granted approval for the establishment of a Section on Military Medicine.

Reports of Other Councils and Committees Were Approved by the House of Delegates with no specific recommendations being made.

Resolutions Presented to the House:

Several other resolutions were presented by several states during the first session of the House of Delegates. The following action was taken on these at the final session, following hearings by the various reference committees.

Clinical Sessions: The House approved the supplemental report of the Board of Trustees calling for the continuation of the Clinical sessions.

Study of Association's Public Relations Program: The House approved the appointment of a special committee to study the public relations program of the association.

Action on H.R. 5865: This bill, now pending in the Congress House Committee and calling for federal aid for the establishment of full-time health departments, was opposed by the House of Delegates. This bill has since been reported as being shelved by the Committee in Congress.

Establishment of a Federal Department of Health: The House approved the idea of introducing a bill which would recommend the establishment of a Federal Department of Health with executive status, this department to be a separate department whose duties would be the correlation of all health activities of the government.

Resolution Calling for the President and President-Elect to be Made Members of the Board of Trustees: This was referred by the House to the Standing Committee on Constitution and By-Laws.

Resolution Calling for the Past Presidents to be Made Members of the House of Delegates: The House felt that the best purposes of the Association would not be served by such a move and, therefore, declined to approve this resolution.

Resolution Requesting Allotment of Two Members to the House of Delegates: For States Having Less than 1,000 Members: Defeated.

Resolution Calling for Definition of the Word "Ex-Officio" As Used: Referred to the Judicial Committee.

Resolution Calling for Free Choice of Physicians by Federal Employees: It was felt that the time was not appropriate for the introduction of such legislation, and suggested that the intent of the original resolution introduced at the June meeting be continued for the time being.

Resolution Calling for the Inspection of all Mili-

tary Hospitals Both Here and Abroad by the A.M.A. and to Not Permit Private Practice in These Hospitals: While the House agreed with the intent of the resolution, it was pointed out that much progress has been made in this field already, and it felt no action was necessary on the part of the association.

Council on Medical Service: In approving the report of the Council on Medical Service the House recommended the expansion of the Committee's activities and staff.

Resolution Calling for Compulsory Insurance of Veterans and Dependents for Hospital and Medical Care: This was killed by overwhelming vote.

Resolution Calling for the Establishment of a Fund from Dues for Aid to Schools of Medicine: Approved.

Resolution Opposing Federal Aid to Medical Education; but calling for such aid on a voluntary basis, and stating that if such Federal aid was made available that it be made available with explicit agreement that no Federal control would be exercised. Carried.

Resolution on Implementation of Hess Report: It was felt that when a complaint is received that a joint meeting of the Judicial Council and the Committee on Medical Education and Hospitals should be held before any statement is made, and that such action should be initiated at the county level. Approved.

Resolution Condemning Hospitals for Infringing On the Practice of Medicine: It was felt that the Hess report had brought about an agreement and established a policy in this matter, therefore no action was deemed necessary.

Hospital Standardization Program: A resolution opposing the taking over of the Hospital Standardization program by the American Hospital Association was introduced. The House felt that no action was necessary in view of the recent discussion between groups concerned with this matter. The House did approve the report of the Board of Trustees.

Resolution on Temporary Sickness Cash Benefit Plans: This resolution called for support by the A.M.A. of plans that might be enacted into law or instigated on a voluntary basis for the provision of cash benefits to workers who are unemployed because of illness not connected with their occupation. It was felt that this matter required more study and consideration before any statement of policy is made. Therefore, no definite action was taken.

Place of 1952 Clinical Session. Denver, Colorado, was selected as the site for the 1952 Clinical session. The 1951 Clinical session is to be held in Houston, Texas.

Joint Meeting Held: On Thursday, a joint meeting was held with the House of Delegates and representatives of the National Education Campaign from the various states. Indiana again was recognized as leading all other states in the procurement of resolutions. The field secretary, Mr. James A. Waggener, participated in a group of panel talks on the subject, "State Participation in Medicine's National Campaign."

Highlight of the Thursday session was the address delivered for Mr. William L. Hutcheson, General President, United Brotherhood of Carpenters and Joiners of America, in which this Union, a member of the A. F. of L., aligned itself with medicine in opposing any form of government compulsory health insurance. The address was read by Mr. Peter E. Terzick, Editor of *The Carpenter* in the absence of Mr. Hutcheson, who was ill.

Indiana had one representative serving on a reference committee. Dr. F. S. Crockett, Lafayette, served on the Reference Committee on Emergency Medical Service.

Indiana physicians registered at the meeting were as follows:

Bibler, Lester D., Indianapolis
Black, Edgar K., Wabash
Boswell, Robert W., Evansville
Bunde, Carl A., Indianapolis
Challman, William B., Mount Vernon
Cockrum, William M., Evansville
Cortese, James V., Indianapolis
Crimm, Paul D., Evansville
Denny, E. Rankin, Washington
Dukes, Betty J., Dugger
Dukes, Joseph E., Dugger
Dunning, Lehman M., Indianapolis
Elliott, John C., Guilford
Ellis, George M., Connersville
Hall, Emory H., Dunkirk
Hamer, Homer G., Indianapolis
Harkcom, H. E., Sr., St. Paul
Heritier, C. Jules, Columbia City
Hochhalter, Marion, Logansport
Huffman, Park, Whitley
Irey, P. R., Plymouth
Jones, E. S., Hammond
Karn, John W., South Bend
Kennedy, Hunter F., Indianapolis
Kirtley, William R., Indianapolis
Laudeman, W. A., Elwood
McCaskey, Carl H., Indianapolis
McNaughton, L. M., Washington
Matthews, B. J., Indianapolis
Maurer, Robert M., Brazil
Mitchell, Albert M., Terre Haute
Murphy, Josephine F., South Bend
Nelson, Raymond E., South Bend
Palm, John M., Brazil
Paris, Durward W., Kokomo
Ragsdale, H. C., Bedford
Ruddell, Karl, Indianapolis
Schafer, Donald William, Fort Wayne
Scheetz, M. R., Lewisville
Schetgen, Joseph V., Geneva
Sensenich, R. L., South Bend
Sheehan, Francis G., Indianapolis
Stinson, A. E., Rochester
Strange, J. W., Loogootee
Teal, Dorothy D., Columbus
Wagoner, John B., Colburn
Washburn, Will W., LaFayette
Weigand, C. G., Indianapolis
Wright, J. William, Indianapolis

News Notes

HEART SYMPOSIUM

The second annual Heart Symposium for practicing physicians, presented by the Indiana University School of Medicine, in cooperation with the Indiana Heart Foundation, will be presented on Wednesday, February 14, 1951, in the medical school auditorium, from 10:00 a.m. to 5:00 p.m. This symposium is open to all physicians without advance registration or fees.

POSTGRADUATE COURSE IN ELECTROCARDIOGRAPHY

The annual Postgraduate Course in Electrocardiography will be presented by the staff of the Indiana University School of Medicine, on Thursday and Friday, February 15 and 16, 1951. Registration is limited to twenty-five. Registration fee is $25.00. For information and registration address the Recorder's Office, Indiana University School of Medicine, 1040 West Michigan Street, Indianapolis 7.

NATIONAL CONFERENCE ON RURAL HEALTH

The A.M.A. Committee on Rural Health, with Dr. F. S. Crockett of Lafayette as chairman, is sponsoring the sixth annual National Conference on Rural Health, to be held in Memphis on February 23 and 24, 1951. The conference is held in cooperation with national farm organizations, and more than 700 farm and health leaders are expected to attend. The day before the conference opens will be devoted to a meeting of the chairmen of state rural health committees. Organization of community health councils will be stressed.

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL
The Department of Postgraduate Medicine

BRIEF REVIEW COURSES FOR PRACTICING PHYSICIANS
1951

Anatomy (Thursdays)	February 15-May 31
Cancer	January 16-19
Internal Medicine:	
Diseases of the Heart	March 19-23
Endocrinology and Metabolism	March 26-30
Rheumatic Disease	April 2-6
Diseases of the Blood	April 16-20
Diseases of the Gastro-Intestinal Tract	April 23-27
Recent Advances in Therapeutics	May 3-5
Electrocardiographic Diagnosis	August 27-Sept. 1
Neurology, Clinical	May 14-17
Obstetrics and Gynecology	February 19-March 3
Ophthalmology Conference	April 23-25
Pediatrics	February 28-March 3
Roentgenology, Diagnostic	April 16-20

For further information about these courses, write to Howard H. Cummings, M.D., Chairman, Department of Postgraduate Medicine, 2040 University Hospital, Ann Arbor, Michigan.

NATIONAL CONFERENCE OF MEDICAL SERVICES

The twenty-fourth annual meeting of the National Conference on Medical Services will be held Sunday, February 11, 1951, in the Red Lacquer room of the Palmer House in Chicago. The meeting is of special importance to presidents, secretaries, and public relations personnel of state and county medical societies.

POSTGRADUATE RADIATION PROGRAM

Dr. Isadore Lampe, who has perfected many of the modern technics used in x-ray treatment of cancer and is known as an authority on radiation therapy, has been appointed Visiting Professor of Radiology for a two-day postgraduate radiation program being presented Thursday and Friday, January 11-12, at the Indiana University Medical Center.

All interested physicians are invited to attend the program, presented by the School of Medicine with the support of the Indiana Cancer Society, Dean John D. Van Nuys stated, in announcing that Dr. Lampe was the first of a series of noted leaders on various phases of cancer treatment who would visit the Medical Center in coming weeks.

Dr. Lampe's program for the two days will include:

Thursday,

January 11—Gynecology-Radiology Conference; Department of Radiology, 8:30 to 10 A.M.

—Pediatric Radiology Conference, Riley Hospital, 1 to 2 P.M.

—Lecture, 'Concepts of Radiosensitivity and Radiocurability,' Clinical Building, auditorium, 7 P.M.

Friday,

January 12—Radiation Therapy Conference, Department of Radiology, 9 to 10:30 A.M.

—General Tumor Clinic, Clinical Building Auditorium, 1 to 2 P.M.

—Address: 'Evaluation of Radiotherapy in Carcinomas of the Female Reproductive Organs,' Medical School auditorium, 8 P.M.

Among delegates from Indiana who attended the **Midcentury White House Conference on Children and Youth** at Washington, D. C., in early December were **Dr. E. R. Carlo** of Fort Wayne, **Dr. Byron N. Lingeman** of Crawfordsville, **Dr. L. E. Burney** of Indianapolis and **Ray E. Smith,** executive secretary of the state medical association. The conference defeated a recommendation that it go on record favoring a total and permanent disability clause in the Social Security Act, and took no stand on the issue of socialized medicine.

NEW TYPE OF ARMY MEDICAL COMPANY TO SEE SERVICE IN KOREA

A preventive medicine unit of company size, first of several of its kind now being organized by the Army Medical Service, has arrived in the Far East Command for duty in Korea.

Successor to the malaria survey and malaria control detachments which played key roles in the Southwest Pacific and elsewhere during World War II, the new company has functions beyond the scope of previous units of this type. In addition to malaria control and survey, the units will be responsible for inspections of field sanitary conditions and control of insect-borne, water-borne and other diseases. When acting in support of combat troops, these companies will operate as far forward as necessary to accomplish their mission.

AMERICAN BOARD OF OPHTHALMOLOGY

Candidates for the certificate of the American Board of Ophthalmology are accepted for examination on the evidence of a Written Qualifying Test. These Tests are held annually, in January, in various parts of the United States. *Applications are now being accepted* for the 1952 Written Test. Applications for the 1952 Written Test must be filed before July first at the Executive Office, 56 Ivie Road, Cape Cottage, Maine.

CANCER GRANTS

Grants of $620,603 to strengthen the nation-wide attack on cancer were announced recently by the Federal Security Administrator. Included were the following for Indiana:

Institution and Project Director	*Description of Project*	*Amount Granted*
Indiana University, Bloomington, Dr. Ernest E. Campaigne	Synthesis of compounds of the carbazole series for their possible chemotherapeutic or carcinogenic action.	$1,998
Indiana University Medical Center, Indianapolis, Dr. Edward W. Shrigley	(1) To study the effect of virus infection upon the metabolism of chick embryos by the use of radioactive isotopes, (2) to study metabolism of viruses and virus-induced tumors, and (3) develop qualitative tests for Rous virus	6,480
	Total	$8,478

THE AMERICAN COLLEGE OF PHYSICIANS ANNUAL SESSION

The American College of Physicians will conduct its 32nd Annual Session at St. Louis, April 9-13, inclusive, 1951. Dr. Ralph Kinsella of St. Louis is the General Chairman and will be responsible for local arrangements and for the program of Clinics and Panel Discussions. Dr. William S. Middleton, President of the College, Madison, Wisconsin, will be in charge of the program of Morning Lectures and afternoon General Sessions.

PAN-PACIFIC SURGICAL ASSOCIATION

The Fifth Congress of the Pan-Pacific Surgical Association will be held in Honolulu November 10 to 21, 1951. Further information may be obtained by writing the Pan-Pacific Surgical Association office, 7 Young Building, Honolulu, T. H.

MEDICAL STUDENTS MET IN CHICAGO

Delegates representing student bodies in medical schools in the United States met at A.M.A. headquarters in Chicago, December 28-29, to draft a constitution for the Student American Medical Association. Dr. Walton Van Winkle, Jr., Chicago, secretary of the A.M.A. Committee on Research, is serving as temporary executive secretary of the student association during its pre-organization period.

The organization is to be a national association of medical students and is to be affiliated with the A.M.A. Formation of such a student group was approved by the House of Delegates at San Francisco last June.

SOUTHEASTERN INDIANA HEALTH CONFERENCE

Three members of the Indiana State Medical Association took part in the third annual Health Conference for Southeastern Indiana, held on the campus of Franklin College, November 15. Sponsored jointly by the Indiana State Board of Health, State Department of Public Instruction, Indiana Congress P.T.A., Indiana State Medical and Dental Associations and the host, Franklin College, the conference drew an attendance of 125.

The theme for the conference was "Building an Integrated Program for Your School and Community."

Drs. Julia S. Thom, Indianapolis, and Walter L. Portteus, Franklin, participated in a panel discussion concerning "The Responsibility of the Home and the School in Helping the Child to Adjust to School."

Dr. George E. McCoy, of Muncie, discussed the subject of "Screening for Physical Defects," later participating in a panel discussion of the subject, "Making School Health Services Meaningful to The Community, The Parent, and The Pupil."

Dr. Lawerence Shinabery, of Fort Wayne, was elected president of the Association of American Physicians and Surgeons, when it held its annual meeting in Houston in October. Dr. Arthur G. Blazey, of Washington, and Dr. James L. Doenges, of Anderson, were elected directors. The 1951 annual meeting will be held at the Claypool Hotel in Indianapolis on October 4, 5 and 6. Dr. Paul T. Lamey, of Anderson, is the annual meeting chairman.

"DO YOU HAVE A MAID?"

Not so very many households these days can answer yes, but those who do have a maid or any other household worker will need a copy of a brief booklet bearing that question as a title. Mr. Harold O. Mountjoy, Manager of the Indianapolis Social Security Office, is distributing this booklet. This colorful leaflet sets out, in a few sentences, just how the lady of the house, or any employer of domestic help in or around the home, may tell whether or not the worker is brought under the new social security law which became effective on January 1.

The work of those regularly employed in private homes will be credited to social security and the employer will be responsible for reporting wages, along with social security taxes, to the Collector of Internal Revenue.

The title of the pamphlet does not stop with "Do You Have a Maid?" but continues "—or a laundress?—a cook?—chauffeur?—gardner?" Any of these or any other persons employed regularly for work in or around a private household may come under the new law, and Mr. Mountjoy urges their employers to request a free copy of the booklet.

A simple test in the booklet, in terms of amount of wages paid and regularity of employment, will tell whether a maid or cook or laundress will get the protection of social security—and whether the housewife should start making reports this year. If so, there's a postage-paid postal card in the government-issued booklet which the housewife should mail in for instructions.

Copies of the booklet are available at all post offices, or may be secured at offices of the Collector of Internal Revenue. In Indianapolis call the social security office, telephone MA-1581, or drop a post card, asking for the booklet, "Do You Have a Maid" and it will be sent to you by return mail. Address of the office is Social Security Administration, 36 South Pennsylvania Street, Indianapolis 4.

The "Do You Have a Maid" booklet does not apply to domestic work on farms operated for profit. Such work is covered by other provisions in the new social security law.

REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS

A competitive examination for appointment of Medical Officers in the Regular Corps of the United States Public Health Service will be held on February 12, 13, and 14, 1951. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received no later than January 15, 1951.

Application forms and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C., attention: Division of Commissioned Officers. Applications received after January 15, 1951, cannot be accepted.

LUNG CANCER STUDY

An attempt to isolate the various factors suspected of contributing to lung cancer will be made under a Public Health Service grant. Lung cancer patients at several Massachusetts hospitals will be interviewed for information on smoking habits, exposure to occupational hazards, previous lung diseases, hereditary background, and possible air impurities in the environment.

By analyzing the complete backgrounds of a large number of lung cancer patients, Dr. L. S. Snegireff of Harvard College and Dr. Herbert L. Lombard of the Massachusetts Department of Health hope to determine the importance of tobacco smoking as compared with other environmental influences.

The possible connection of cancer and occupational factors that are not under special study in other states, such as various nonferrous metals, will be investigated through a grant to the Connecticut State Department of Health.

Appointment of Miss Jayne Shover, an outstanding authority on the rehabilitation of handicapped children, as associate executive director of the National Society for Crippled Children and Adults is announced by Lawrence J. Linck, executive director.

Miss Shover for the past five years has been director of program services and the cerebral palsy division of the National Society, which is a nationwide federation of 2,000 societies serving the crippled in all 48 states.

She has also served as director of speech and hearing and as an assistant in guidance for the East Chicago public schools; and assistant director of the speech and hearing clinic at Purdue University. She also serves on the special advisory board of the Lake County Chapter of the Indiana Society for Crippled Children.

Dr. Herbert McMahan, chief psychiatrist of the Manteno, Illinois, state mental hospital, has been appointed medical superintendent of the Norman M. Beatty Memorial Hospital at Westville. Doctor McMahan is a native of Anderson, and a graduate of the Indiana University School of Medicine. He spent his internship at Indianapolis General Hospital, and took postgraduate work at the Illinois Neuropsychiatric Institution. Following four years in the army as a psychiatric examiner, Doctor McMahan went to the Manteno Hospital, where he has served for four years.

Dr. Edwin A. Dyar, of Indianapolis, is chairman of the professional committee of the Indiana Committee of the **National Society for the Prevention of Blindness**. Other association members on the professional committee are: **Dr. Samuel M. Baxter**, of New Albany, **Dr. William M. Cockrum**, of Evansville, **Dr. J. V. Cassady**, of South Bend, **Dr. Hugh A. Kuhn**, of Hammond, **Dr. Noel S. McBride**, of Terre Haute, and **Dr. Maurice Rothberg**, of Fort Wayne.

Announcement has been made recently that **Dr. John Housley** is now associated in the general practice of medicine at Albion with **Dr. John W. Morr**. Doctor Housley has been practicing in Huntington and Spencerville.

Dr. Leo R. Nonte is now associated with **Dr. Paul W. Steele** at the East Side Surgical Clinic in Evansville. Doctor Nonte is a 1941 graduate of Indiana University School of Medicine, and a veteran of World War II. Following his release from service, he took a five-year residency in surgery.

Dr. Jack Porter, of Lebanon, has been commissioned a first lieutenant in the Air Force Medical Corps reserves, and reported for active duty in San Antonio, Texas, on January 2.

Dr. Robert L. Rudesill, of Indianapolis, is taking a two year residency at the Mayo Clinic.

Dr. Boynton H. Booth has opened an office for the practice of dermatology at 910 Hume Mansur Building, in Indianapolis. A 1943 graduate of the University of Illinois School of Medicine, Doctor Booth served for three years with the Armed Forces, eighteen months of which were in the European Theater. He served his internship and took three years of postgraduate training in Chicago.

Dr. William M. Huse, a veteran of World War II, has opened an office for the practice of obstetrics and gynecology at 805 Hume Mansur Building in Indianapolis. Doctor Huse is a 1943 graduate of Indiana University School of Medicine, and interned at St. Vincent's Hospital in Indianapolis. Following two years in the service he returned to St. Vincent's Hospital, for three years of postgraduate training.

Dr. Howard A. Bosler opened an office in Waterford recently for the general practice of medicine. For the past nineteen years Doctor Bosler has served in a leprosarium in Garkida, West Africa.

Dr. James F. Reilly, of Vincennes, has opened an office in Decker for the practice of medicine.

Dr. Harry D. Tripp has announced the opening of an office in Bloomington, for the practice of surgery. He has been in practice in Plymouth for the past five years.

Dr. Fred H. Priebe has opened an office in Hillsboro for the practice of medicine. A graduate of the Cincinnati University School of Medicine in 1945, he served for two years with the Army Medical Corps, and then took two years of residency training in internal medicine.

Dr. Charles L. Lippoldt, of Batesville, was called to active duty with the Air Force in November. He reported to Chanute Field, Illinois.

A 1943 graduate of the Indiana University School of Medicine, **Dr. C. W. Lambert** has opened an office for the practice of orthopedics in Los Angeles.

Dr. Richard C. Datzman, a 1944 graduate of Indiana University, is now associated in the practice of radiology with **Dr. Jack L. Loudermilk**, in Fort Wayne.

Dr. George C. Weinland, a 1947 graduate of Indiana University School of Medicine, is now in active military service, and is stationed at Fort Bragg, North Carolina.

Dr. Robert D. Solomon, formerly of Chicago, recently became associated with **Dr. Leon L. Blum** in the practice of pathology in Terre Haute. Doctor Solomon is a 1942 graduate of Johns Hopkins Medical School and received his residency in pathology at the Michael Reese Hospital, Chicago, and University of Illinois Medical School, where he was also engaged in cancer research. During World War II, Doctor Solomon served three years of active duty in the Medical Corps in the Southwest Pacific Theater of War.

A.M.A. WASHINGTON OFFICE NEWS

New CDA Takes Over Medical Defense Planning. Medical and other phases of civil defense planning have been shifted from National Security Resources Board to the new *Civil Defense Administration*, which President Truman created by executive order. Extent of CDA's power at present is not clear, but legislation giving the agency unprecedented authority is pending in Congress. Purpose of CDA is to knit together regional and local defense organizations and to give the federal government the right to use a strong hand if other organizations are unable to act in a disaster. Its *medical* program calls for establishment of regional medical offices and stockpiling medical supplies. Mr. Truman appointed Millard F. Caldwell, Jr., as director of CDA and said it would be financed with emergency funds pending action by Congress. Mr. Caldwell is a former governor of Florida and a former Congressman.

Administration Loses Voting Strength in New Committees. Republican gains in both House and Senate mean a loss to the administration in committee as well as floor votes, a realignment which could be significant on several committees which handle *legislation in the medical and health field.* Leaders of both parties will work out the number of Democrat and Republican seats in conference, but the net effect will be *more Republicans* and *fewer Democrats* on most important committees—and less chance for purely administration legislation of any sort to be reported favorably.

In the House, the Democrats will have no more than 236 votes, a loss of about 24 votes for most roll calls. This should mean additional Republican seats on large committees, including Armed Services, Expenditures in the Executive Departments, and Interstate and Foreign Commerce. All of these committees will be handling legislation important to the medical profession.

The same situation will exist in the Senate, where Republicans are in line for more voting power on such medically-important committees as Labor and Public Welfare, Expenditures in the Executive Departments and Armed Services.

Army Speeds Up Commissioning Procedure: Military Notes. *Army* has stepped up its procedure for commissioning of medical reserves in an effort to insure that no man who wants to volunteer will be involuntarily inducted and deprived of the $100 bonus.

Here is the new system:

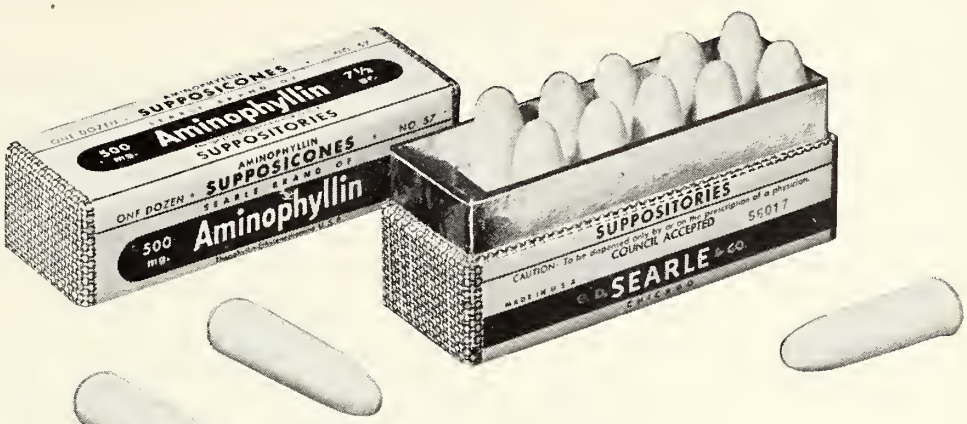
At the time a registrant *reports for physical examination*, he has an opportunity—his last—to apply for an army reserve commission as a volunteer. If he accepts, his records go to the Army area commander, who sends a letter of appointment if the registrant qualifies in other respects. Once he receives this notice, the registrant is expected to take the oath of office within 72 hours. Then he is to notify his Selective Service Board of his reserve status, and SS will cease processing him.

Larger Armed Forces, New Call for Physicians in Sight. Unless there is an about-face in military planning, substantial numbers of physicians not now anticipating military duty will have to be called up in the next year. Although military medical planners have made no announcement of new requirements, some facts are inescapably clear.

Between July 1 and December total military manpower was increased from 1,500,000 to about 2,200,000. Until the new Korean crisis, the goal was *2,800,000 by next July 1.* Physicians to care for the additional men were expected to come mainly from doctor-draft registrants classified 1-A and 1-A-O, and reserves who otherwise would be so classified. However, the services now plan to speed up inductions and reach the *2,800,000 total by early spring.* This means that the present pool of 1-A's and 1-A-O's and draft-eligible reserves will be used up earlier than anticipated. After that, the *services will have to call on physicians not now classified 1-A or 1-A-O and possibly again reach into the ranks of reserves with World War II experience.*

In his request to Congress for additional defense money, President Truman did not specify a new manpower total, *but he left no doubt that a figure higher than the current goal of 2,800,000 would be set.* Mr. Truman said: "We now face the necessity of having to raise our sights both in terms of manpower and in terms of production."

It should be remembered that last fall the services' request for a *3,500,000* ceiling was not approved. If, in view of the new crisis they should get authorization for this total, *several thousand additional physicians would be needed.* Officially, military leaders decline to set a troop ratio for physicians, but unofficially some of them agree that four per thousand would not be too far from the actual figure. Against a 700,000 increase in troop strength, *this would mean almost 3,000 additional medical officers.*



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Halpin, L. J.: An Appraisal of Therapeutic Procedures in Bronchial Asthma, J. Iowa M. Soc. 39:468 (Oct.) 1949.

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RESEARCH IN THE SERVICE OF MEDICINE SEARLE

Deaths

Ralph J. Anderson, M.D., of Indianapolis, died suddenly on December 5, at the age of sixty-five. A graduate of the Indiana University School of Medicine in 1915, he had practiced in Indianapolis for thirty-five years. Doctor Anderson was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Edward T. Edwards, Sr., M.D., of Vincennes, died on November 6 after a long illness. He was sixty-five years of age. He graduated from the Indiana University School of Medicine in 1910. He was a veteran of World War I, and was a former member of Knox County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Ernest N. Johnson, M.D., of Sandborn, died on November 23. He was seventy years of age. He was a member of the 1909 class of the Indiana University School of Medicine, in Indianapolis, and had practiced in Sandborn since that time, until his retirement in 1948.

Hilbert P. Klein, M.D., of Fort Branch, died on October 30. He was seventy-seven years of age. He graduated from the Eclectic Medical College of Cincinnati in 1897, and had practiced medicine for fifty-two years, for the past twenty-nine years in Fort Branch.

Loring C. Meek, M.D., of Tiosa, died on November 7 at the age of seventy-nine. He was a graduate of the University of Illinois College of Medicine, in 1897, and had practiced in the vicinity of Rochester for fifty-two years. He was an Honorary member of the Fulton County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Lawrence R. Miller, M.D., of Winslow, died suddenly on November 3, at the age of sixty-nine. He graduated from the Kentucky School of Medicine in Louisville in 1907, and began the practice of medicine that year in Winslow, where he continued to practice for forty-three years. Doctor Miller was a member of the Pike County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Charles H. Emery, M.D., of Bedford, died on November 20, at the age of eighty-three. He began the practice of medicine in Bedford in 1893, following graduation from the Michigan University School of Medicine, at Ann Arbor, in 1892. Doctor Emery was an Honorary member of the Lawrence County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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Diefenbach, W. C., and Meneely, J. K., Jr.: Yale J. Biol. & Med. 21:421, 1949.

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

THORACIC SURGERY. By Richard H. Sweet, M.D., Associate Clinical Professor of Surgery, Harvard University Medical School. Illustrations by Jorge Rodriguez Arroyo, M.D., Assistant in Surgical Therapeutics, University of Mexico Medical School. 345 pages with 155 illustrations. Price $10.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa., 1950.

PATHOLOGIC PHYSIOLOGY: Mechanisms of Disease. Edited by William A. Sodeman, M.D. The William Henderson Professor of the Prevention of Tropical and Semi-Tropical Diseases, Tulane University of Louisiana School of Medicine; Senior Visiting Physician, Charity Hospital of Louisiana; Consultant in Medicine, U. S. Marine Hospital at New Orleans. 808 pages with 146 figures and 30 tables. Price $11.50. W. B. Saunders Company, West Washington Square, Philadelphia, Pa., 1950.

SANTA CLAUS, M.D. By W. W. Bauer, M.D., Director of Health Education for A.M.A. and editor of "Today's Health." 265 pages. Price $2.75. The Bobbs-Merrill Company, Inc., 730 North Meridian Street, Indianapolis 7, 1950.

THE PROSTATE GLAND. By Herbert R. Kenyon, M.D., associate clinical professor, Department of Urology, New York University, Bellevue Medical Center. 194 pages. Price $2.95. Random House, 457 Madison Avenue, New York 22, N. Y., 1950.

PARS PRO TOTO. Abbreviations in International Medical Literature, Including Sister Sciences in Six Languages. By Alfred Peyser. 196 pages. Almqvist & Wiksell, Stockholm, Sweden, 1950.

PRINCIPLES OF GENERAL PSYCHOPATHOLOGY. By Siegfried Fischer, M.D., clinical instructor in psychiatry, University of California. 327 pages. Price $4.75. Philosophical Library, New York, 1950.

RESEARCHES IN BINOCULAR VISION. By Kenneth N. Ogle, Ph.D., research consultant in Section on Ophthalmology, Mayo Clinic, Rochester, Minn. 345 pages, with 182 figures. Price $7.50. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa., 1950.

A TEXT-BOOK OF X-RAY DIAGNOSIS. By British Authors, in four volumes. Edited by: S. Cochrane Shanks, M.D., director X-Ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M.D., director X-Ray Department, Westminster Hospital, London. Second Edition. 830 pages with 694 illustrations. Price $18.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa., 1950.

PRINCIPLES AND PRACTICE OF SURGERY. By Jacob K. Berman, M.D., associate professor of surgery, Indiana University School of Medicine, Indianapolis. 1378 pages, with 429 illustrations. Price $15.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis, Mo., 1950.

EYES AND INDUSTRY (formerly Industrial Ophthalmology) Second Edition. By Hedwig S. Kuhn, M.D., Hammond. Foreword by Albert C. Snell, M.D., Rochester, N. Y. 378 pages, with 151 text illustrations, including three color plates. Price $8.50. C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Mo., 1950.

SIR WILLIAM OSLER—Aphorisms from his Bedside Teachings and Writings. Collected by Robert Bennett Bean, M.D., and edited by his son, William Bennett Bean, M.D., professor of Medicine and Head of the Department of Internal Medicine at the State University of Iowa College of Medicine, and member of the editorial board of the Journal of Laboratory and Clinical Medicine. 159 pages. Price $2.50. Henry Schuman, Inc., 20 East 70th Street, New York 21, N. Y., 1950.

THE PHYSICIAN EXAMINES THE BIBLE. By C. Raimer Smith, M.D., a physician in general practice who has made a hobby of studying the Bible. 394 pages. Price $4.25. The Philosophical Library, Inc., 15 East 40th Street, New York 16, N. Y., 1950.

FREUD: DICTIONARY OF PSYCHOANALYSIS. Edited by Nandor Fodor, associate of the Association for the Advancement of Psychotherapy; and Frank Gaynor. Preface by Theodore Reik. 208 pages. Price $3.75. The Philosophical Library, Inc., 15 East 40th Street, New York 16, N. Y., 1950.

This book is a complete glossary of all the basic terms in psychoanalysis as defined and explained in the words of Dr. Sigmund Freud. The definitions are taken word for word from the epochal writings of Doctor Freud, a complete study of all his writings being accomplished to insure the most informative definitions.

This glossary is an extremely convenient and useful reference work for the psychologist, psychiatrist and psychoanalyst.

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**Pitt, C.K.: The Art and Science of Artificial Infant Feeding, J.M. Asso. Ala. 19:101 (Oct.) 1949.*

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BOOKS REVIEWED

ESSENTIALS OF OPHTHALMOLOGY. By Roland I. Pritikin, M. D., eye surgeon, Rockford Memorial, Winnebago County, and Swedish-American Hospitals, consulting ophthalomologist, St. Anthony Hospital, Rockford, Illinois. 561 pages, with 215 illustrations, including 18 in color. Price $7.50. J. B. Lippincott Company, East Washington Square, Philadelphia, Pa., 1950.

This is one of the Lippincott essential series which are designed as handy reference works for physicians.

The scope is exceptionally wide, touching on every phase of ophthalmology.

It includes chapters on physiology, eye examination, muscles and refractive errors, including the fitting of glasses, all of which are seldom found in other manuals or small texts on eye disease.

The material is up-to-date and well presented. I believe the inclusion of more photographs of the commoner eye conditions would be an aid to the average physician.

This is certainly one of the best of the smaller works, giving a compendious coverage of the field of ophthalmology. R. F. C.

IMMORTAL MAGYAR: Semmelweis, Conqueror of Childbed Fever. By Frank G. Slaughter, M.D. 211 pages. Price $3.50. Henry Schuman, Inc., 20 East 70th Street, New York 21, N. Y., 1950.

Immortal Magyar; Semmelweis, Conqueror of Childbed Fever is one of the first books to be published in a series of about one hundred books to be known as the Life of Science Library. The purpose of this series of books is to present for the general reader the history of major developments in science.

The author of this book, Dr. Frank G. Slaughter, is a well-trained surgeon with considerable experience. He has now retired from the practice of surgery and has become one of the country's most popular writers of medical fiction, although this work is an authentic biography of one of the most colorful and tragic personalities in medical history.

The whole work is scientifically accurate and historically authentic. Most physicians are familiar with the pioneer work of Semmelweis in the etiology of puerperal infection, and how he was derided and antagonized by the obstetrical authorities of his day, who viewed progress with an uncompromising authority, and not without antipathy.

Fortunately such an attitude does not prevail among medical men today. Totalitarianism is past in medicine, but unfortunately political science has not made such progress.

The book is pleasant reading and contains much information for both the physician and lay reader. It is hoped that the other books in the series of The Life of Science Library will be as readable and authentic as this volume on the life of Semmelweis.

This small volume makes a handsome gift for a physician, medical student or any extensive reader.

AN ATLAS OF HUMAN ANATOMY. By Barry J. Anson, Ph.D., Professor of Anatomy, Northwestern University Medical School. 518 pages. Price $11.50. W. B. Saunders Company, Philadelphia, 1950.

This is indeed a book "prepared in such a way as to be continuously useful to the reader from his days as a novitiate through those in which his responsibilities as a doctor require a reference book based, not upon perennially copied figures, but upon the artists' unbiased portrayal of dissection." Thus speaks the author in his preface, and a perusal of the work bears out his claim.

An outstanding feature of the "portrayal of dissection" is the high quality of the art work throughout. Indeed, how can one review in words a work which is 99.44 percent pictures? But, of course, artists require models, and much credit must go to those who prepared the dissections and to the author for his vision and systematic approach.

Doctor Anson has improved greatly, in this reviewer's opinion, on the old method of presenting anatomy by systems. Instead, he considers each region, such as head, neck, upper extremity, back and thorax, etc., as a unit, and dissects it from the surface inward in great detail. The different systems (bones, joints, muscles, vessels, etc.) are delineated both separately and together, thus giving a more complete concept of structure in three dimensions and as related to function than is usually achieved in an atlas. In addition, variations and anomalies, while not emphasized at the expense of the "normal," come in for their share of attention, including statistics on frequency observed in actual dissections. Where variations are of definite surgical importance, such as the obturator artery, tendons of the hand, level of termination of spinal cord, etc., ample space is allowed. As an example, 6 types and 4 subtypes of attachment of the ileum, cecum and ascending colon to the dorsal body wall are given, with 18 diagrams to illustrate the same, all based on dissections of 125 specimens. In addition to the diagrams, 12 excellent drawings are presented showing variations in the vermiform process.

Advances in surgical technique and boldness since the days of Spalteholz are reflected in the large amount of space devoted to such structures as the lungs, bronchi, heart, thymus and esophagus, in the thorax and the stomach, duodenum, biliary system and pancreas in the abdomen. Variations in the hepatic pedicle alone comprise 24 drawings and 13 diagrams, based on 500 specimens.

There are not many faults, and those noted may represent personal feeling. Tabling for the most part is adequate, but there are places where comprehension of the dissection could be facilitated in this respect. It is also a little confusing to find the legend referring at one time to the left of the drawing and at another to the left of the specimen. Medical custom has long referred to the left or right, dorsum or ventrum, of the specimen or of the patient, both in illustration and in description, and all anatomical terminology has the same basis, so that it seems unnecessary and unfortunate to introduce even slight confusion in this respect.

There is a great deal of valuable information in the legends to the illustrations, presumably by Doctor Anson, himself, and the entire work bears the stamp of high quality in original conception, art work, organization and reproduction on the printed page. A. W. C.

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—OCTOBER 1950

Disease	Oct. 1950	Sept. 1950	Aug. 1950	Oct. 1949	Oct. 1948
Brucellosis	2	9	4	5	6
Chickenpox	90	21	8	72	80
Diphtheria	15	8	9	34	47
Encephalitis	2	2	2	3	4
Erysipelas	2	2	0	1	0
Food Poisoning	6	0	0	5	0
Impetigo	12	2	1	3	0
Influenza	32	3	1	18	16
Infectious Hepatitis	2	0	0	0	0
Measles	21	19	17	87	19
Meningitis,					
Unclassified	3	3	1	4	1
Influenzal	1	1	1	0	0
Mumps	59	21	9	42	67
Pneumonia	42	18	20	1	0
Poliomyelitis	157	175	88	192	67
Rabies in animals	35	31	25	59	43
Rubella	2	14	3	11	1
Scarlet Fever	67	29	20	77	110
Tetanus	2	4	1	2	0
Tinea Capitis	53	6	1	28	6
Tuberculosis,					
Pulmonary	142	150	142	219	165
Other forms	4	12	12	14	5
Typhoid fever	6	4	16	3	11
Whooping cough	153	123	90	88	35
Tularemia	1	3	4	0	3

MONTHLY REPORT—NOVEMBER, 1950

Disease	Nov. 1950	Oct. 1950	Sept. 1950	Nov. 1949	Nov. 1948
Brucellosis	5	2	9	0	7
Chickenpox	177	90	21	140	368
Diphtheria	4	15	8	38	38
Amoebic dysentery	2	0	0	3	11
Encephalitis	3	2	2	2	4
Food poisoning	26	6	0	1	0
Influenza	21	32	3	20	105
Infectious hepatitis	3	2	0	0	0
Measles	37	21	19	92	93
Meningitis,					
Unclassified	3	3	3	5	3
Influenzal	2	1	1	0	2
Meningococcal	2	0	0	2	1
Mumps	90	59	21	72	72
Paratyphoid fever	1	0	2	0	1
Pneumonia	62	42	18	26	65
Poliomyelitis	105	156	175	65	19
Animal rabies	38	31	25	36	54
Rheumatic fever	1	0	3	0	1
Rubella	2	2	14	15	4
Scabies	14	0	0	0	0
Scarlet fever	62	67	29	118	136
Tetanus	1	2	4	1	2
Tinea capitis	21	53	6	7	0
Tuberculosis,					
Pulmonary	162	142	150	168	137
Other forms	14	4	12	18	6
Tularemia	4	1	3	0	10
Typhoid fever	2	6	4	3	3
Vincent's angina	2	0	0	0	2
Whooping cough	151	153	123	88	68

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THE POTENTIALITIES AND LIMITATIONS OF SYMPATHETIC NERVE SURGERY*

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INDIANAPOLIS

THOUGH the paravertebral sympathetic chains were described in the second century by Galen, many years were to pass before the precise anatomical features of the sympathetic nerves became reasonably well understood. Indeed, Galen's error of considering the sympathetic and vagal trunks as a single structure originating in the cranial cavity was not corrected for 1,500 years. Knowledge of the physiology of the autonomic nerves developed even more slowly. Finally, however, through the work of many investigators a relatively satisfactory working knowledge of the sympathetic nerves was evolved.

The principal overall function of the autonomic nervous system appears to be its important role in the adaptation of the body to changing environmental conditions and psychic states. This concept of the part played in maintaining homeostasis was developed as a result of the contributions of such men as Bichat, Bernard and Cannon. Meanwhile, the specific local effects of sympathetic function had been clarified to a certain extent. For example, in 1852 Claude Bernard had described the evidences of increased blood flow following sympathetic denervation. He called attention to the local increase in skin temperature which occurs after division of the cervical sympathetic trunk and stated "All the part of the head which becomes hot after section of the nerve becomes also the seat of more active circulation. The arteries especially seem fuller and appear to pulsate more forcibly." At the same time Brown-Séquard demonstrated the vasoconstriction which accompanies stimulation of the sympathetics.

The first operation upon the sympathetic nervous system in man was a cervical sympathectomy performed in an effort to cure epilepsy by the Liverpool surgeon Alexander in the 1880's. The Roumanian Jannesco carried out this procedure on a large number of patients with epilepsy, and the French surgeon Jaboulay tried its effect in exophthalmic goiter. None of these efforts were very fruitful and several years passed before interest in sympathetic nerve surgery was revived. As White and Smith have pointed out,*[1] the work of Francois-Franck underlies the first successful operation upon the sympathetic nerves. This author stated with clarity: "The entire sympathetic system is endowed with direct sensory fibers and carries centripetal fibers from the heart and aorta to the cord and brain stem. It seems logical to assume that sympathectomy acts as much in suppressing abnormal afferent impulses to the higher

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* One chapter of this excellent monograph provides an interesting account of these historical developments and contains references to the more important publications.

centers as in blocking efferent stimuli to the thyroid and heart. This new idea of aortic pain carried by the cervicothoracic sympathetic nerves suggests the thought of trying their resection in angina pectoris." Nearly 30 years later Jannesco demonstrated the accuracy of this prediction and thus initiated the use of sympathetic denervation for the relief of visceral pain.

The possibility of favorably influencing the circulation to an extremity was suggested by Leriche's experiences with periarterial sympathectomy, even though subsequent experiences with this procedure have shown that it does not consistently bring about a state of vasodilatation. It remained for the observation of striking improvement in blood flow evident in those patients treated by sympathetic ganglionectomy in a vain effort to relieve muscle spasticity according to the proposal of Hunter and Royle to serve as an incentive for the study of possible applications of sympathetic surgery in the various disorders of the peripheral circulation.

Though much remains to be accomplished, the twenty-six years which have elapsed since then have witnessed a most gratifying advance in our appreciation of the potentialities and limitations of surgery of the sympathetic nerves. I shall discuss them briefly. Elsewhere some of my experiences with sympathetic nerve surgery have been recorded in more detail.‡[2-14]

Some possible benefits of sympathectomy are suggested by certain physiologic alterations which occur in the area of denervation and a consideration of these changes will also make evident certain limitations. The three principal effects are: first, absence of cutaneous sweating in the area of denervation; second, blocking of vascoconstrictor impulses and consequent maintenance of a state of maximal or near-maximal circulation; and, third, amelioration or relief of certain painful states.

ANHIDROSIS

Sweating is a function of cutaneous sympathetic innervation. In the absence of disease of the sweat glands sympathetic activity results in profuse sweating; sympathetic denervation results in anhidrosis. This effect of sympathectomy serves as the primary indication for operation in cases of hyperhidrosis in which the excessive sweating alone or some direct effect of the profuse sweating, such as a malodorous condition or maceration of the skin, constitute the only or chief disability or annoyance. Though not common, neither are these cases of so-called idiopathic hyperhidrosis rare. Any part of the body may be affected, but generally it is the hands, feet or face. The difficulty may not only be a distressing annoyance, which interferes with ordinary daily activities and normal social relationships, but it may completely disrupt the patient's ability to work. Examples are the chemist whose delicate measurements are constantly being ruined by inadvertent contamination of the material with sweat, or the worker who finds he cannot keep a job because his fellow workers will not tolerate the disagreeable odor which accompanies his excessive sweating. The hyperhidrosis may, in addition, cause serious maceration of skin. Such constantly wet skin provides an ideal soil for fungus infection and, indeed, it may be virtually impossible to get rid of chronic infections of this sort without first abolishing the hyperhidrosis.

Any of these effects of hyperhidrosis may provide sufficient grounds for operative sympathetic denervation. No preoperative test, such as procaine sympathetic block, is required, for anhidrosis invariably results from sympathectomy. The results are eminently satisfactory since the complaint literally disappears. Fortunately, too, the good results are long lasting; rarely, even after many years, is a properly performed sympathectomy for hyperhidrosis of the feet, hands or face followed by return of sweating to the affected area.

The anhidrosis which is a sequel to sympathetic denervation must obviously be reckoned with whenever this procedure is contemplated for some condition other than hyperhidrosis itself; generally this effect is beneficial. In conditions of reduced arterial circulation, for example, sweating serves to increase the heat loss by evaporation and thus the need for greater blood flow. Furthermore, it tends to promote maceration of skin and epidermophytosis, conditions which may initiate infectious processes and ischemic disasters. The dry skin which follows operation, though preferable to the condition it supersedes, must nevertheless be cared for properly in order to prevent scaling and fissures. Such difficulties can easily be prevented by the simple expedient of local application of lanolin or some similar grease as is required.

In some instances the anhidrosis which follows sympathectomy must be looked upon as a necessary minor nuisance. Such is the case, for example, when sympathectomy is performed for causalgia without vasospasm or for hypertensive disease. Generally the resulting absence of sweating is, of itself, of little concern; the skin is easily and properly cared for with a minimum of effort. Even when the anhidrosis is extensive, comprising practically the entire body surface, patients rarely complain of difficulty of adaptation to hot weather; far more commonly complaints are directed to the compensatory excessive sweating which so often occurs in the remaining areas of normal innervation. Practically, this complaint rarely if ever follows denervation of one, two or even three extremities. It is rather common after sympathetic denervation of all four extremities and after very extensive lumbodorsal sympathectomy for hyper-

‡ In these papers there are bibliographies which include the important contributions published in this field and, for the sake of brevity, they will not be referred to in this review.

tension. Generally, however, the disorder for which the operation is done is sufficiently serious that its relief or improvement far outweighs the inconvenience of this sequel. Furthermore, the hyperhidrosis of the residual normal skin seems to become less severe as time passes.

In conclusion, therefore, it may be said that the anhidrosis which follows sympathectomy is generally beneficial and is rarely troublesome to any significant degree.

ABOLITION OF VASOCONSTRICTION

The second effect of sympathectomy mentioned, namely the abolition of vasoconstrictor impulses, constitutes by far the commonest primary indication for carrying out the procedure. The conditions in which sympathectomy may be indicated because of this effect are many. In the first place, there are those disorders which are entirely or principally vasospastic in nature. They include Raynaud's disease, Raynaud's phenomenon due to some specific cause such as the use of vibrating tools, acrocyanosis, the more ill-defined vasospastic disorders of unknown cause, the vasospastic conditions which may follow frostbite or trench foot, the posttraumatic reflex disturbances characterized by coldness, cyanosis, hyperhidrosis or sensitivity to cold, and livedo reticularis associated with vasoconstriction. In general, sympathectomy is an extraordinarily useful measure in these conditions but its intelligent application is dependent upon accurate diagnosis and familiarity with the response to sympathectomy of the particular condition under study.

Sympathetic denervation, for example, is followed by superb results in acrocyanosis, in the ill-defined vasospastic disorders mentioned, in the posttraumatic vasospastic reflex disturbances and in livedo reticularis accompanying vasospastic states. It is a generally useful measure for the vasospastic difficulties which may follow frostbite and is effective in relieving the coldness, cyanosis, hyperhidrosis and cold sensitivity which often follow trench foot, but is apt to have little or no beneficial effect upon the pain on weight-bearing which is the commonest severe complaint after this type of cold injury. It remains the most useful therapeutic measure in severe Raynaud's disease though perfect results are not obtained in every case. Invariably attacks initiated by emotional excitation cease, and attacks resulting from exposure to cold generally disappear completely or recur with much less frequency and severity. In general the results are better if treatment is instituted before serious organic changes such as scleroderma, digital ulceration, bone atrophy, et cetera, have taken place. For some reason not properly understood, apparent return of sympathetic activity with the passage of time appears to be more frequent when the operation is carried out for Raynaud's disease than for any other disorder.

When dealing with the vasospastic disorders, if one is sure of the precise disagnosis and is well acquainted with the effect of sympathectomy in that particular condition, it may be unnecessary to study the effect of abolition of sympathetic impulses before making a decision regarding operation. If any doubt exists, however, it is mandatory to evaluate the result of sympathetic anesthesia, or possibly of some other method of blocking vasoconstriction and inducing vasodilatation, carried out under the precise conditions which aggravate the vasospasm. Indeed such a test is sometimes actually necessary in order to establish the diagnosis as well as to determine the probable effect of operation.

A second group of conditions comprise those in which there is an organic obstruction to arterial circulation; it includes the obliterative arterial diseases, arteriosclerosis, thromboangiitis obliterans, and some of the rarer sorts of arteritis. By far the commonest of them is arteriosclerosis accompanying, or not accompanying, diabetes. When the circulation to an extremity is impaired by organic occlusion of an artery or arteries, improvement in circulation is dependent upon obtaining maximal blood flow through the patent collateral channels. The capacity of these vessels to dilate cannot be predicted except as the result of observation of the response of the part, the circulation to which has been stabilized in a cool atmosphere, to one of the measures which block vasoconstrictor impulses and lower vascular tonus. These methods include heating of the body or of uninvolved limbs, preferably fortified by the ingestion of alcohol, sympathetic block, somatic nerve block, spinal or general anesthesia. The method selected for use should be based upon the particular situation at hand.

Several points may be stressed as important. The accuracy of the results of the test should not be compromised by telling the patient beforehand what favorable change is going to take place; a patient at wit's end with constant agonizing rest pain, for example, may be so desperate for relief that he may grossly exaggerate the slightest possible improvement. Rather the patient should be told that the transient result which will follow is unpredictable, that no alteration may occur, or the condition may be improved or made worse. Observation of the extremity cannot be terminated within a few minutes since the vasodilator response may be slow in developing, especially when methods of reflex vasodilatation are being used. If failure to demonstrate a capacity for vasodilatation follows some test, such as body heating, it is wise to repeat the study using a more certain method, such as sympathetic, peripheral nerve, or spinal anesthesia. If no increase in blood flow is evident after an attempted sympathetic block one must make certain, by such means as comparison of cutaneous resistance of the limb under study and of the contralateral one, that sympathetic anesthesia was actually achieved. Otherwise one might mistake

an ineffective sympathetic injection for lack of capacity for vasodilatation. If pain is a complaint, sympathetic block should be used in preference to other methods for only with this method can one evaluate the probable effect of sympathetic denervation upon the pain. Furthermore, if pain is present only under certain specific circumstances, those circumstances must be reproduced during the period of effective sympathetic anesthesia.

In general, if good vasodilatation results from one of these tests one may anticipate that sympathectomy will bring about improvement in circulation. Whether it will be judged that this improvement will be sufficient in any given case will obviously depend upon one's experience with such conditions. Even slight increase in blood flow may save a limb with a cold cyanotic toe, representing what is generally termed "threatened gangrene." If, on the other hand, in an elderly person with arteriosclerosis gangrene is well established and extends into the mid-foot, it is equally obvious that amputation will be required and that it must be carried out through the leg or at a higher level. In this case sympathectomy may be helpful, perhaps in making more certain good healing of the stump, but it surely cannot possibly save the foot. Experience has shown that even when sympathetic block brings about no apparent increase in blood flow, sympathectomy may occasionally yield a better result than would be expected. Such unexpected good results are, however, rather uncommon and the response to preoperative study still serves as a generally good guide to whether or not sympathectomy should be performed. Nevertheless, there are certain instances where it seems justifiable to chance the effect of operation in the absence of a favorable preoperative response. In general, careful evaluation of the effect of sympathetic anesthesia upon rest pain serves as a reliable means of predicting the result of operation. In my experience, the same is not true of intermittent claudication. The results of determining the exercise tolerance during a period of sympathetic anesthesia have often enough been at variance with those which followed operation that I have felt it justifiable to omit such tests. These patients are told frankly what the overall results are. Some few have amazing relief, many have slight or moderate improvement, and many can walk no farther without pain or fatigue even though improvement in other respects is perfectly apparent.

Quite similar to the problem of the chronic obliterative diseases is that of the sudden loss of patency of a major artery through embolism, thrombosis, injury or surgical division. Often very gratifying improvement can be brought about in cases of arterial thrombosis, or in cases of arterial embolism with evident impairment of circulation unfortunate enough not to have been treated successfully by embolectomy. The efficacy of sympathectomy in cases of traumatic division or thrombosis, or in the case of elective surgery for aneurysm or arteriovenous fistula varies, as in all other circumstances, with the extent of the collateral channels and the capacity of the collateral bed to undergo vasodilatation.

In summary, it may be said that sympathectomy provides the best method for insuring maximal effectiveness of the collateral arterial channels in cases of impaired circulation due to interruption of blood flow through important arteries as the result of organic obstruction or traumatic or surgical interruption. Its effectiveness varies with the extent of these collaterals, with their freedom from, or involvement with, sclerotic disease and thus with their capacity to undergo alteration of tonus. Generally speaking, the young will do better than the aged but in a matter so important it is hazardous to guess what effect elimination of vasoconstrictor impulses will have and much wiser to base the decision upon an actual test. Fortunately studies of this sort require no elaborate equipment. It is preferable to have a room which can be maintained constantly at a cool temperature, oscillometers, thermocouples and similar instruments, but if one can find a cool room and will carry out properly one of these tests, any significant response will be evident to the trained eye and palpating finger.

A third general application of sympathectomy, because of its abolition of vasoconstriction, is its use in the treatment of hypertension. Unfortunately in this disease the true cause is unknown and hence up to the present no curative measures, in the strict sense of the word, have been developed. It is unfortunate, too, that the manifestations of this disease are so varied and its natural history so inadequately known that it is well-nigh impossible to predict in any given case what the future course of events would be if no treatment at all were given. Because of this fact, it is exceedingly difficult to evaluate objectively the results of any method of treatment. It would seem fair to say, however, that as years have passed more physicians as well as surgeons have been impressed with the help which may be derived from sympathectomy and splanchnicectomy.

There is no doubt whatsoever that such symptoms as headaches and giddiness almost invariably disappear, even when no remarkable reduction in blood pressure follows operation, and that such relief tends to be long lasting. Not infrequently there are other observable changes for the better, less cardiac dysfunction, reduction in heart size, and improvement in electrocardiography. The blood pressure response to operation is variable. If the denervation is sufficiently extensive there always, or nearly always, develops some postural hypotension but this hypotension differs in degree from patient to patient. In some it is so severe as to require the use for a time of abdominal belt compression and elastic support of the lower extremities. The postural hypotension becomes less marked with the passage of time and may disap-

pear altogether, though there is generally a continued tendency for the blood pressure of patients treated surgically to be highest in the recumbent and lowest in the erect position. In some the blood pressure may be relatively normal in all positions after sympathectomy and this change may persist for years. In others the recumbent pressure returns to a fairly high level sooner or later but the pressure in the standing position remains considerably lower. In still others any significant decrease in blood pressure is rather brief in duration.

It should be pointed out, however, that the patient is essentially concerned with his state of well being and is less concerned with such matters as the level of his blood pressure, and that relief of symptoms occurs rather regularly regardless of the effect upon blood pressure. I know of no more grateful or generally satisfied patients than those who have undergone extensive sympathectomy for hypertension.

Furthermore, difficult as it is to be sure that two series of cases are comparable, recent comparisons of large numbers of patients treated by operation, such as those of Smithwick,[15] with others treated by nonoperative measures, would seem to indicate clearly that operation not only brings about symptomatic improvement but prolongs life as well. The same conclusions are reached when operatively and nonoperatively treated groups of cases with specific complications such as cardiovascular difficulties are compared, as was recently done by White and his associates.[16]

The problem of selection of cases for operation is very difficult for, though it appears evident that the likelihood of a successful outcome varies inversely with the severity of the disease, it is the severely ill who plead most earnestly for treatment. In general, the younger the patient, the more labile the blood pressure, the better the renal and cardiac function and the freer of disease the peripheral arteries, the better the result which can be anticipated. And yet it is true that amazingly good results sometimes follow operation upon patients who are judged rather poor candidates for operation. Any progress made in more accurate selection of patients who are likely to do well following sympathectomy will obviously increase the general effectiveness of the procedure.

Though the question of the most desirable extent of operation is still debated, it seems fair to say that a rather extensive operation is preferable to a limited one. I have been pleased with the results of total sympathectomy and a somewhat less extensive procedure in which the denervation is complete below the fourth thoracic level.

PAIN

There remains to be considered the third effect of sympathetic denervation mentioned, namely, its influence upon certain painful states. I have previously mentioned that the first successful application of sympathetic nerve surgery was Jannesco's operation for the relief of angina pectoris. This remains a useful procedure and if the patient seems too ill for operation, the appropriate portion of the upper dorsal and lower cervical sympathetic chain can be paralyzed by alcoholic infiltration. Sympathetic denervation is similarly useful in the relief of certain types of intractable intra-abdominal visceral pain. It is obvious that such a measure should be used only when the condition causing the pain cannot be corrected by reasonably safe measures. Certainly there was good reason for employing sympathectomy and splanchnicectomy for the relief of pain from recurrent or chronic pancreatitis and pancreatic calculosis in preference to the more serious and risky procedure of pancreatectomy. If, however, such pain can be relieved, as initial experiences suggest it can be, by simple division of the ampulla of Vater, this measure should eliminate the use of sympathetic denervation in such cases. It should be pointed out that only visceral pain can be relieved by appropriate operations upon the sympathetic nerves; if the process involves the parietal structures as well, relief of pain will be incomplete.

I have also previously referred to the frequent benefit of sympathectomy in cases of pain associated with reduced arterial circulation. As I pointed out, the degree of relief obtained is generally proportionate to the improvement in circulation which results. Sometimes, however, the relief of pain is striking even when little or no improvement in blood flow is evident. Such cases have caused considerable speculation as to the mechanism involved. The relief of visceral pain offers no problem, for it is recognized that there are afferent pain fibers in the sympathetic nerves innervating these organs. The relief of pain in ischemic states also presented no problem as long as it was associated with marked circulatory improvement; one would assume the pain was due to ischemia and disappeared with restitution of satisfactory blood flow. The exceptional cases, however, have been very puzzling. Similarly difficult to understand is the dramatic relief of pain following sympathetic interruption in cases of major causalgia in which the vasomotor status may be one of increased, decreased or normal vascular tonus, in cases of certain painful posttraumatic reflex disorders, in cases of painful postphlebitic ulcers and other ulcerated lesions not apparently associated with vasoconstriction. The apparent lack of afferent fibers in the peripheral sympathetics has necessitated the postulation of some unusual mechanism and several interesting theories have been propounded. From recent experimental observations which my colleagues and I have made it seems that the peripheral sympathetics may, however, carry afferent impulses. If such is the case, the role of the sympathetic nerves in the relief of pain becomes more readily understandable.

It is fortunate that the various operations upon

the sympathetic nerves can be accomplished with relative safety. Several years ago when I reviewed my experiences and those of my associates with the operative sympathetic denervation of 813 extremities in 627 patients, I found that there had been only one postoperative death in 607 lumbar sympathectomies and none in 206 upper dorsal sympathectomies. To date the mortality for lumbar sympathectomy is only a trifle higher and there have not as yet been any deaths after sympathetic denervation of the upper extremities. In a number of clinics the operative mortality in cases of hypertension has been kept at a respectably low figure (around 5 percent or less), considering the severity of the illness for which the procedure is performed. Since adoption of the transthoracic and extrapleural technique which I am currently using, there has been one death in 66 operations upon 35 patients.

SUMMARY AND CONCLUSIONS

The potentialities and limitations of sympathetic nerve surgery have been reviewed. These procedures constitute a valuable part of our therapeutic armamentarium. It is important that we understand their wide range of usefulness and at the same time appreciate those factors which limit their effectiveness.

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THE TREATMENT OF STERILITY*‡

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PHILADELPHIA

THE FREQUENCY of the barren marriage, as well as its social implications, make the management of sterility a dynamic medical problem. The success of treatment depends in large measure upon the care devoted by the physician and upon the earnestness of the interested couple. The physician who undertakes the care of a barren marriage must not only subscribe fully to the concept of the multiple causation of sterility but must also pursue a fixed plan of study. Such a plan "includes an orderly systematic history of the sterile couple, an unremitting search for multiple etiologic factors in each partner, and persistence in eliminating all possible impediments to conception, regardless of how minor they may seem to appear."[1] The barren couple must, on the other hand, be willing to submit to the search for etiologic factors, the detection of which takes both time and patience. Their cooperation is easy to obtain if the physician properly orients them initially.

A sterile union does not generally arise from reproductive defects in only one partner but is usually rather the result of the sum total of several factors, often minimal, in both partners. Appreciation of this fact is responsible for the current formulation of the so-called "minimal diagnostic survey." The systematic investigation of a barren marriage is not so formidable a ritual as to discourage any interested family physician. He may certainly plan and, in some measure, execute the searching formula. A few of the studies do require particular facilities and special skills, but such examinations may be performed either by consulting specialists or in diagnostic clinics. Bearing in mind the physiology of conception, as well as the multiple reasons for its dysfunction, the physician should seek to uncover the following essential etiologic factors:

I. Gross pelvic disease, such as tumors and infections, conditions contravening the initiation and maintenance of gestation.

II. Male infertility which finds expression clinically in faults of the semen.

III. Errors of cervical insemination, which include failure to deposit the semen properly in the vagina, defective invasion of the cervical canal by spermatozoa and hostility of the cervical secretion.

IV. Tubal occlusion, partial or complete.

V. Endocrine faults in the female, which include temporal abnormalities of menstruation and deficiencies of ovulation.

The incidence of these various factors in the multiple etiology of barrenness varies with the type of practice conducted by the physician. In some series, multiple causes are found in nearly two-thirds of the couples.[1] The present survey of 245 barren couples, collected from the files of the authors during the past four years, omitted all patients with a gross pelvic cause of the sterility. Considering the remaining four groups, it was noted that multiple faults occurred in 25 percent. (Table I.)

TABLE I

The Incidence of Etiologic Factors in 245 Barren Couples in Whom the Female Partner Was Free From Gross Pelvic Disease.*

Factors‡		Percentage Incidence
I. MALE INFERTILITY		
Oligozoospermia	39.5%	
Azoospermia	13.5	53.0%
II. ERRORS OF CERVICAL INSEMINATION		
Faulty technic	1.2	
Cervical lesions	23.1	24.3
III. TUBAL OCCLUSION		
Partial	19.3	
Complete	10.7	30.0
IV. ENDOCRINE FAULTS IN THE FEMALE		
Amenorrhea	1.2	
Oligomenorrhea	6.5	
Anovulation	10.3	18.0

* Barren couple: no conception after **one year** of continuous marital life without use of contraception.[11, 12]

‡ In 61 of the 245 couples (25 percent) a combination of two or more of the four remaining major factors coexisted.

I. GROSS PELVIC DISEASE

The finding of any gross pelvic abnormality during the initial gynecologic examination suspends further investigation of the barrenness until the disorder in question is evaluated. The largest number of such grossly palpable conditions are of inflammatory origin. However, asymptomatic myomas and congenital malformations of the

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uterus, as well as tumors of the ovary, are also encountered in women who seek aid because of sterility. The treatment of these conditions is not germane to the present report. The purpose of this presentation is to lay emphasis upon those measures which yielded the largest measure of success in couples free from the overwhelming handicap of a gross (female) pelvic disorder.

II. MALE INFERTILITY

The clinical approach to the management of male infertility must diagnostically consider endocrine disturbances, malnutrition, genital infection, disturbances of testicular circulation, and cryptorchidism. The history of the husband must be thoroughly elicited, special emphasis being placed upon genitourinary difficulties and sexual habits. The latter need not conform to any particular pattern. It is important, however, that the frequency of coitus be such that it occurs during the probable time of the wife's ovulation. On the other hand, it should *not* be daily during that period since fertility is thereby adversely affected. In most men, repeated ejaculation at intervals of less than 24 hours causes a reduction of the number of spermatozoa,[2, 3] as well as an increase in the number of abnormal forms.[4]

In estimating the fertility of the male, emphasis must be placed on complete physical examination, a study of the semen, and, if required for differential diagnosis, testicular biopsy. The latter is a simple procedure for a urologist and entails no incapacitation.[5] If the semen's deficiency is the result of defective germinal tissue, the degree of involvement and the probable regenerative capacity of the tubular epithelium may be observed in the biopsy. If occlusion is responsible, well-constructed seminiferous tubules will be seen. Thus, biopsy allows prognostication, aids the selection of proper treatment, and enables the avoidance of useless therapy in complete tubular degeneration.

Assuming that the proper study has been done, the male will be found to fall into one of three categories, namely, fertile, relatively infertile, and sterile. The latter is based on a diagnosis of *irremediable azoospermia*, confirmed by finding degenerated testicular tubules in the biopsy. If there are normal seminiferous tubules in the presence of azoospermia, the urologist should attempt to overcome the obstruction. The majority of infertile males will show *oligozoospermia*, a reduced spermatozoal population. Study of the male partners in our group of 245 barren marriages revealed a semen abnormality in 53 percent—oligozoospermia in 39.5 percent and azoospermia in 13.5 percent.

Oligozoospermia is best managed by the following measures:

1. Correction of faulty habits and diet.
2. Maintenance of proper weight.
3. Correction of any hypothyroidism by use of desiccated thyroid substance.
4. The elimination of adnexal infection by means of repeated prostatic massage and, on occasion, lavage of the seminal vesicles. (Endocrine therapy appears to be of little value in the male.)

III. FAULTS OF CERVICAL INSEMINATION

Penetration of the cervical mucus by a large number of spermatoza is essential to fertility. This necessitates both the proper vaginal deposition of normal semen and a salutary state of the cervical canal. These factors may be evaluated by microscopic study of the postcoital cervical and vaginal secretions, the *Sims-Huhner test*. It is important in having the test performed to consider the cyclic physiology of the cervix, for spermatozoa penetrate the cervical mucus best at the time of ovulation[6] when the mucus is most abundant, has a high content of water, is well supplied with glycogen, and possesses its lowest viscosity.[7] It is better not to prescribe a definite day for the test, allowing the couple to select one of several days approximating ovulation after at least three days of sexual abstinence. The physician may thus determine that the patient has endocervicitis, a cervical polyp, the absence of proper cervical mucus, or merely an anterior position of the cervix. Our 245 barren couples demonstrated faults of cervical insemination in 24.3 percent, 1.2 percent representing faulty coital technic and 23.1 percent visible cervical lesions. (Table I.)

In the correction of these abnormalities of the cervix, the patient may be subjected to injections of antibiotics, repeated dilatation of the stenotic cervix to permit drainage, the removal of pedunculated polyps, radial cauterization of an erosion, and the use of small doses of estrogen over a long period of time to stimulate the continued production of cervical mucus. A proper oral dose of estrogen for this purpose is 0.25 mg. of diethylstilbestrol, taken daily for from six to eight weeks.

IV. TUBAL OCCLUSION

An evaluation of tubal function is indispensable in the study of sterility. It may be established either by uterotubal insufflation with carbon dioxide (Rubin test) or by uterosalpingography. These methods are not in competition for each is advantageous under varied circumstances. The *Rubin test* is more commonly employed because it is simple and expedient, being possible of execution "anywhere by a single individual." *Uterosalpingography*, requiring radiographic technic and equipment, is most valuable in estimating tubal closure demonstrated by the Rubin test. In order to avoid unfavorable reactions, neither of these diagnostic methods should be applied in the presence of acute or chronic pelvic disease, an imminent menstrual flow, a systemic disorder, and less than a month

apart. Tubal occlusion was a factor in 30.0 percent of the women in the 245 barren couples—19.3 percent presented partial occlusion and 10.7 percent complete tubal occlusion. (Table I) The incidence of occlusion would doubtless be higher if we accepted the initial Rubin test as being accurate. As a matter of fact, if a negative reading is obtained during the first test and a positive one during the succeeding test, the patient is considered to have exhibited tubal spasm but to have patent tubes.

The management of *partial tubal occlusion* should include the frequent use of pelvic heat, the administration of the small doses of estrogen, and repeated Rubin tests. The pelvic heat may be applied in the form of daily hot douches, diathermy, or any of the apparata designed to administer pelvic heat in a closed vaginal circuit. The dose of estrogen employed should be small, similar to the one employed to stimulate cervical mucus, but protractedly administered in an effort to evoke tubal peristalsis. The repeated Rubin tests are essential aids, and should be performed monthly immediately after the cessation of menstruation.

When *complete occlusion* is demonstrated, it is necessary to decide on the advisability of surgically correcting the fault. It cannot be expected to yield more than a 10 percent measure of success. If there is no other cause of the barrenness, if the occlusion is bilateral, and if the patient is made aware of the relatively unpromising character of the treatment, she may be subjected to one of the varieties of tuboplasty. The type of tubal reconstruction must vary with the site of tubal obstruction. The operations are not technically difficult. The problem resides in the subsequent management of the patient, which aims to maintain the surgically-obtained tubal patency. To that end, repeated postoperative tubal insufflations are absolutely essential. These should be initiated *within a few days* of the plastic operation and continued at biweekly intervals for several months.

V. ENDOCRINE FAULTS IN THE FEMALE

Dysfunctional menstrual disorders, amenorrhea, and abnormal bleeding, are obvious handmaidens to sterility. Their presence permits the assumption that an endocrine derangement in the female exists. *Anovular menstruation*, on the other hand, is clinically indistinguishable from normal menstruation and its presence must be excluded in every barren woman by some proof of cyclic ovulation. Of the 245 patients analyzed herein, 18.0 percent gave evidence of endocrine faults—1.2 percent had amenorrhea, 6.5 percent oligomenorrhea, and 10.3 percent were either completely anovulatory or ovulated at grossly irregular intervals. (Table I.)

Dysfunctional Menstrual Disorders. The management of menstrual aberrations of functional origin, while not appropriate to this review, must be mentioned in order to indicate the importance of their correction prior to the initiation of pregnancy. The faulty reproductive career of women with ovarian dysfunction has been properly emphasized by Day and Smith.[8] The measures which best regulate such temporal faults of menstruation are the cyclic administration of the ovarian steroids, estrogen and progesterone, and the application of low-dosage irradiation of the pituitary gland and ovaries.

The *administration of ovarian steroids* may follow one of several patterns. They may be given either together as a combined injection, or separately in a consecutive manner. In the former method the amenorrheal patient may be given a combined intramuscular injection of 2.5 mg. of estradiol benzoate and 12.5 mg. of progesterone on two successive days. Using the consecutive style, one may administer 1.5 mg. of estradiol benzoate intramuscularly every third day for five doses and follow immediately with five daily injections of 10 mg. of progesterone. Such dual therapy, combined or cyclic, should be repeated for three consecutive months.

Low-dosage irradiation of the pituitary gland and ovaries is the most effective and economical means of regulating menstrual rhythm. The mode of action of such irradiation is not understood. One must envisage a small dose of roentgen rays, possibly effective because it "changes intracellular biochemical factors." The dose employed—from 50 to 80 r. per treatment to each site—is only slightly larger than the indifferent dose of x-rays employed in extensive diagnostic procedures of the lower abdomen.[1] The advisability of eliminating the presence of an unrecognized early pregnancy before administering even small-dosage irradiation of the pelvic area is self-evident. If the patient has had a menstrual flow within the preceding ten days, the treatment may be initiated without fear. Otherwise, it is better to evoke a so-called menstrual flow by means of estrogen and progesterone before subjecting the patient to such irradiation. For the very same reason, it is necessary to have the patient avoid pregnancy during the three weeks that the treatment is administered. It is important to have the treatment applied by a roentgenologist who is willing to adhere to the technic described by either Edeiken[9] or by Kaplan,[10] inasmuch as these methods are known to be safe and productive of results.

Anovulatory Menstruation. The diagnosis of anovulatory menstruation as an etiologic factor in sterility rests on the *repeated* demonstration of the failure of ovulation. Inasmuch as the ovaries cannot be inspected during each menstrual cycle, the physician must select other criteria which reflect ovarian function. Currently, the most expedient—though not the most accurate—method is the graphic recording of the daily body temperature. If anovulation is demonstrated by the temperature chart, further investigation of the degree of ovarian failure by means of endometrial biopsy and urinary assays for pituitary gonadotrophin is

indicated. The technic of obtaining premenstrual endometrial tissue for histologic study is simple, and need not be reviewed here. The *interpretation* of the endometrial histology varies with the type of development observed. Endometrial patterns indicative of anovulation or the formation of a defective corpus luteum may include all degrees of proliferation, hyperplasia, and atrophy. The repeated finding, premenstrually, of an atrophic endometrium implies that it is nonresponsive, a condition unrelated to anovulation. To differentiate anovular menstruation from the pseudomenstruation of nondeveloped endometrium, hormonal assays are required. The presence of normal urinary levels of estrogen and of pregnanediol, the execretion product of progesterone, during the premenstrual period exempts the ovary and indicts the uterus.

When the diagnosis of anovulatory menstruation is established, either by temperature graph or by repeated endometrial biopsy, or by both, its endocrine etiology should be sought in assays for pituitary gonadotrophin. If the ovary is primarily at fault, the pituitary gland functioning normally, demonstrably increased urinary excretion of gonadotrophin will be evident. Under the latter circumstances, *progesterone* may be of distinct value. For this special purpose it should be administered during the second half of the cycle in large doses. We have employed 50 mg. of progesterone on the tenth, twelfth, fourteenth, and sixteenth days of the cycle for three successive months. It is not, of course, a panacea for all patients with anovulatory sterility but it does enable a certain number to conceive. It is, at present, one of the most favorable agents in the management of anovulation.

When the ovary is not at fault, there is no demonstrable urinary excretion of gonadotrophin. This suggests that the anovulation may be caused by pituitary failure and implies that the *administration of gonadotrophins* is logical. Both equine and chorionic gonadotrophin, individually and combined, are widely employed. The results, however, do not warrant its widespread use. It is difficult to achieve an orderly sequence of ovarian response to equine gonadotrophin alone. Combined gonadotrophin therapy is better. When employed, the injections of equine gonadotrophin should be given intramuscularly every other day in a dose of 1,500 I.U. during the first half of the menstrual cycle, the last dose being administered just prior to the calculated time of anticipated ovulation. Similar injections of chorionic gonadotrophin should then follow for a period of ten days.

Low-dosage irradiation of the pituitary gland and ovaries, as advocated for the restoration of menstrual rhythm, has been reported favorably by many gynecologists as a treatment for anovulatory sterility. We have found that the administration of the low-dosage irradiation to *regularly* menstruating women, as is the case in anovulation, does not evoke the required changes as well as it does in those in whom irregularity of menstruation exists.

SUMMARY

1. The current practices successfully employed in the management of sterility are presented.

2. It is emphatically stated that the success of treatment depends upon a systematic search for causative faults in each partner. The quest must include the elimination of gross pelvic disease, factors of male fertility, disturbances of cervical insemination, alterations of tubal patency, and derangements of the endocrine-menstrual system.

3. It is affirmed that the prevailing therapeutic agents and technics are the assiduous elimination of cervical infection, the establishment of proper adnexal conditions in the male genital tract, the repeated use of transuterine insufflation for its salutary effect on partially occluded tubes, the administration of low-dosage irradiation to the pituitary gland and ovaries for the restoration of menstrual rhythm, and the injection of large doses of progesterone during the early ovulatory phase for several months.

4. An analysis of a recently treated series of 245 barren couples formed the basis of this presentation.

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RABIES IN INDIANA

A HUMAN CASE

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INDIANAPOLIS

RABIES is said to have been prevalent in Asia in ancient times. Gradually it spread westward, assuming epizootic proportions in Europe early in the eighteenth century.[1] Its first recorded appearance in the United States was in Virginia in 1753. Slowly the disease migrated westward, reaching California in 1889. Statistics from the Bureau of Animal Industry of the United States Department of Agriculture appear to indicate that the incidence of the disease in the United States is increasing.[2]

INCIDENCE IN LOWER ANIMALS

The story of rabies among lower animals in Indiana is imposing. As judged by the number of specimens positive for Negri bodies found at the laboratory of the State Board of Health during the past 35 years, animal rabies has shown a cyclic curve of marked increases followed by periods of lower incidence.[3] A composite curve for the interval would disclose a distinct upward trend. At this time Indiana is among the states that lead the nation in the number of animal heads found positive for rabies. For the decade 1940 to 1949 inclusive, 3,691 positive animal heads were reported. The yearly average for the interval was 369.1. The range was 148 to 805. The lowest year was 1943 with 148 positive heads; the highest year was 1948 with 805 heads positive for Negri bodies. Actually the incidence in 1948 and 1949 was twice the yearly average for the decade. Hence, it appears that, at least in some parts of the state, rabies might be regarded as epidemic in Indiana in 1948 and 1949. The first three months of 1950 were also above the median for the corresponding months of the previous decade. Please refer to Table I and to Map 1.

INCIDENCE IN HUMANS

The story of human rabies in Indiana is depicted in tabular form in Table II.

TABLE II

Human Rabies in Indiana

Year	Deaths Human Rabies	Year	Deaths Human Rabies	Year	Deaths Human Rabies	Year	Deaths Human Rabies
1910	4	1920	1	1930	1	1940	4
1911	4	1921	1	1931	4	1941	0
1912	3	1922	0	1932	4	1942	2
1913	5	1923	1	1933	1	1943	1
1914	0	1924	0	1934	1	1944	3
1915	1	1925	0	1935	2	1945	2
1916	0	1926	2	1936	3	1946	0
1917	2	1927	2	1937	4	1947	1
1918	0	1928	7	1938	2	1948	2
1919	1	1929	4	1939	7	1949	0
							Total 82

Eighty-two deaths attributed to rabies occurred during the 40-year interval. The range was 0 to 7, the median was 2.

Although rabies has not been an important cause of death among humans in Indiana, it has been the cause of either the death or the destruction of many valuable domestic animals. It has also been a major cause of intense mental anguish, of uncertainty as to procedures and of occasional untoward reactions following the administration of prophylaxis to humans. Actually some of the deaths listed in Table II may have been due to the vaccine rather than to the disease.[4] However, it may at first be very difficult to determine that a death from rabies was not caused by the sensitization of the patient's tissue to the foreign protein in the vaccine. It is

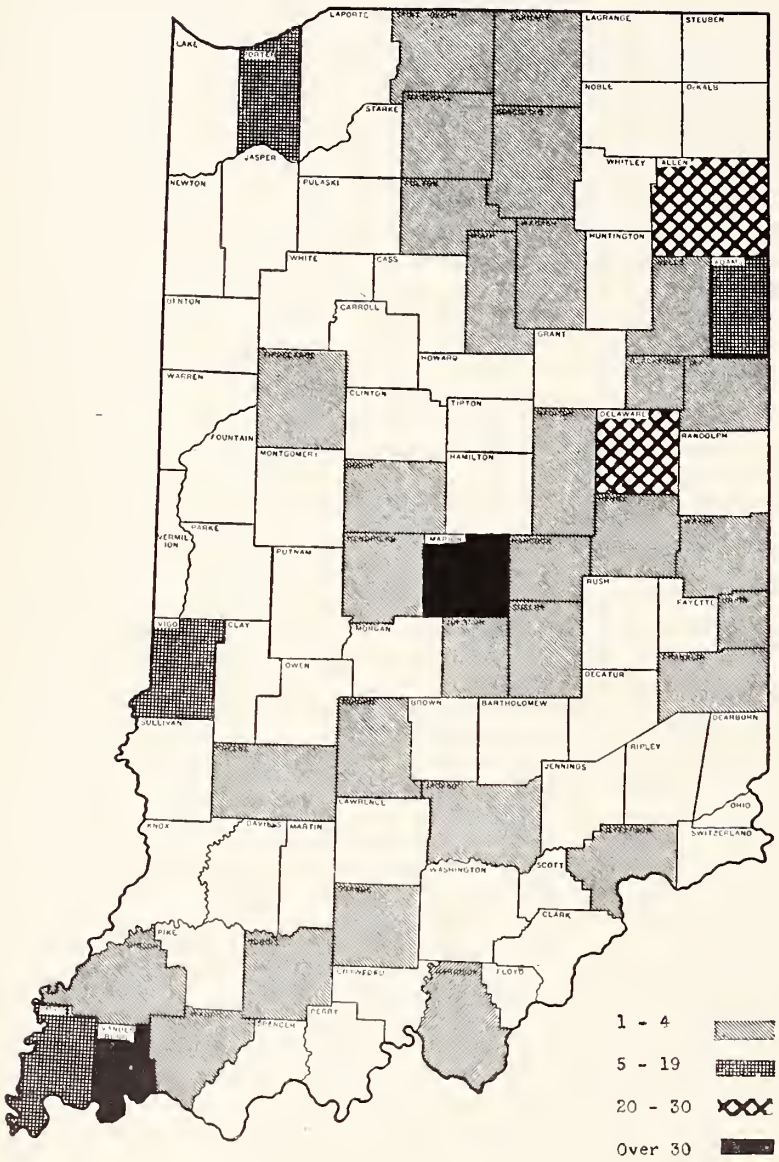
TABLE I.

Morbidity—Animal Rabies, 1940-1949 (Inclusive) Compared by Years and by Months with 1950

	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	Total	Ave.	1950
January	24	17	15	16	12	27	23	28	47	83	292	29.2	29
February	22	28	18	16	28	13	21	39	63	74	322	32.2	55
March	23	32	12	12	31	19	26	28	73	75	331	33.1	30
April	21	25	25	18	26	37	30	28	80	95	385	38.5	70
May	28	17	43	15	30	35	24	31	142	94	459	45.9	52
June	29	18	23	11	22	35	10	20	65	62	295	29.5	
July	18	40	31	7	28	30	20	25	82	69	350	35.0	
August	13	26	15	9	36	21	26	29	60	47	282	28.2	
September	18	17	11	11	23	21	24	24	31	17	197	19.7	
October	27	20	13	9	12	30	28	31	43	59	272	27.2	
November	14	19	8	14	11	23	36	23	54	36	238	23.8	
December	17	14	15	10	19	18	40	31	65	38	268	26.8	
Total	254	273	229	148	278	309	308	337	805	750	3691	369.1	

MAP I.

Animal Rabies During January, February, March and April 1950
Total—214 Reported Cases



especially difficult when Negri bodies are not found at autopsy.

Two additional problems associated with the control of rabies are: (1) the misguided, vociferous, often obstreperous clamor of uninformed cultists, and (2) the unorthodox teaching thrust upon the public by certain columnists. In the control of a disease that causes such horrible suffering in most susceptible animals and which appears to be invariably fatal in humans, neither ignorance nor emotionalism should have the volume and the power to nullify the techniques developed by experience and by scientific analysis applied to research. Yet, it appears that such techniques are usually nullified in this way throughout the nation. Children should not be reared in an atmosphere of false idealism. Instead, they should be encouraged to form the habit of subjecting problems to careful study and critical analysis. This skill, wisely applied to family and community, could be very helpful in reducing the morbidity and mortality incident to rabies in humans as well as in the lower animals. In fancy we could visualize an education—knowledge, attitudes, and skills in the use of the scientific method in the solution of personal and community problems that could have prevented the unnecessary tragedy in Mr. C.'s family.

CASE REPORT

Mr. C. was a white male in the prime of a happy, successful career. He was a leader in his community. He had a charming wife and many friends. He owned a brown Boxer dog about three years of age. The dog, an unusually affectionate animal, had been given one injection of antirabic vaccine in 1947. On a day early in February, 1950, the dog came home with a laceration on one of its legs. Mrs. C., who treated the wound, thought it might have been due to a bite by another dog. Soon thereafter the dog's disposition changed. It developed a bad temper and fought with other dogs in the community. On February 7, after his dog had fought with another neighbor's dog, Mr. C. took it to the Shelter House for observation. This Shelter House was operated under the auspices of the local Humane Society. No veterinarian was available there and none saw the dog at that time. The next day Mr. C. took his dog home. He had the impression that it did not have rabies. It is alleged that some one told him "Your dog is not sick. There is no such disease as rabies." (Recently, a syndicated column favored the opinion that rabies in man is actually tetanus.)

The dog continued to act strangely. Mr. C. put a rope around its neck and tied it to a support in the basement. As he turned to leave the dog attempted to bite him, but he avoided the attack. Then he stepped closer to study the dog's behavior. It lunged at him. In trying to avoid the attack, he

fell. He covered his face with his hands. The dog bit his left hand severely, exposing branches of the median nerve. Mr. C. then strangled the dog into submission and returned it to the Shelter House on 2-8-50. It died there on 2-12-50. The head was sent to the laboratory of the Indiana State Board of Health. On 2-15-50 a positive report was phoned to the local health officer.[5]

The family physician started the administration of antirabic treatment on 2-11-50. The prophylactic chosen was Sharp & Dohme's phenolized antirabic vaccine. Two doses were given daily for a total of 14 doses. These were administered between 2-11-50 and 2-18-50. Then one injection per day was given for 7 days, a total of 21 treatments. No untoward reactions occurred during the treatments. The patient was also given penicillin, tetanus antitoxin and gas gangrene antiserum.

On 3-14-50, eighteen days after the administration of the last dose of antirabic vaccine and 35 days after the bite, Mr. C complained of cramp-like pains in his left hand. The pain appeared to start in the scar resulting from the bite and to radiate up the arm. He also complained of headache, malaise and sore throat. The pain in his arm was not relieved by morphine sulphate in large doses. It evolved into a paralysis of the left arm and a loss of reflexes in that arm only. Mr. C was hospitalized on 3-17-50 at 7:00 A.M. with a diagnosis of "probable treatment paralysis, neuritis type." At that time his temperature was 101.2°, his pulse rate was 122, and the respiration rate was 24. He was nervous; his pupils were contracted, equal, and they reacted to light and accommodation. He could swallow when asked to do so. Fibrillation of the pectoral, arm and forearm muscles was noted. This was more marked on the left side. Fibrillation was also observed in the left thigh muscles. The right biceps reflex was present, but it was impossible to elicit a left biceps reflex. The patient was hypersensitive to pinpricks of the left forearm and hand. There was weakness of flexion and extension of the left forearm and hand. A healed scar was observed in the palm of the left hand, radial aspect, midpalm crease. Kernig's sign was negative.

On admission to the hospital the patient complained of drowsiness and pain in the left arm and hand. He was very nervous. For this demerol, 100 mg., was injected at 11:15 A.M. and another 100 mg. were administered at 2:15 P.M.[6] This gave some relief but apprehension rose again and he complained of tingling and pain in his left arm and side. His temperature dropped to 99.4, his pulse rate to 88 and his respiration rate to 20. He was quite comfortable for about an hour, when nervousness, restlessness and pain again appeared. Demerol ("H) was repeated at 5:10 P.M. and again at 7:15 P.M., but relief was only transient. At 10:15 P.M. he was moaning and tossing in his bed. He complained of aching, numbness and headache. He was able to swallow elixir of phenobarbital, dram. 1, and 2 oz. of water. During the remainder of 3-17-50 his restlessness continued.

At 2:00 A.M. 3-18-50 elixir of phenobarbital, dram. 1, and at 3:15 A.M. sodium amytal, gr. 3, were administered orally. Throughout the morning he was very restless. His neck was massaged. He moaned and tossed in his bed.

After drinking water he complained of difficulty in breathing and of being warm. An ice pack was applied to his head. At 6:00 A.M. on 3-18-50 his axillary temperature was 102.6, his pulse rate was 110 and the respiration rate was 22. He was given elixir of phenobarbital, dram. 1, with water. By 7:00 A.M. he was again restless, complaining of dyspnea and nausea. He was expectorating a nonfrothy phlegm, most of which came from his nose at this time. At 8:00 A.M. he was tossing in his bed and complaining of dysphagia. At 9:00 A.M. blood was noted in the expectorated phlegm. By noon the temperature was 103.0 by axilla and the pulse rate was 112. His nervousness continued. Difficulty in swallowing was noted. Elixir of phenobarbital, dram. 2, was administered in 2 oz. of water. A soft diet, with lemonade and soup, was offered. He had no appetite. He was very nervous, tossing in his bed. Lemonade was taken about 1:00 P.M. By 2:00 P.M. he was irrational, noisy, talking business, selling houses, answering the phone, but at intervals dozing for a few minutes, but later again noisy, irrational, fighting, and expectorating phlegm with blood. At 2:45 P.M. the attending physician administered intravenously 7½ grs. of sodium amytal in 1000 cc. of 5 percent glucose, and 250 mg. of chloromycetin were given orally. At 3:00 P.M. 3 cc. of benadryl were given intravenously. At this time the patient was irrational and fighting to get out of bed. It was necessary to shackle his arms and legs. At 3:30 P.M. 5 grs. of sodium luminal were administered. However, the patient's excitement continued. He was very hard to manage, raving and fighting continuously. Codeine, grs. 1½, were given intramuscularly. At 4:00 P.M. he was expectorating a thick, white sputum. The nasal discharge was bloody. At 5:10 5 grs. of sodium luminal and 2000 cc. of normal saline were given. The patient was very hard to manage. Ten cc. of paraldehyde were given deep-intramuscularly and the patient was put in a strait jacket. At this time his temperature was 107, pulse 168 and respiration 36. The patient was quieter now but aroused when sputum was wiped from his lips. At this time his respiration was shallow and labored. A suction machine was used from time to time as needed to remove thick, tenaceous mucus. Ice caps were applied to the extremeties. The patient perspired freely. The linens were saturated. He was placed in an oxygen tent at 7 liters. At 7:00 P.M. 5 cc. of benadryl were given intramuscularly. Its use was based on the observed fact that benadryl has been found of distinct value in some cases of treatment reactions. He was still restless. Five cc. of paraldehyde were

given deep-intramuscularly. His temperature fell to 104.3, pulse 148, respiration 32. At 8:00 P.M. 1 cc. of penicillin with fortified duracillin were administered intramuscularly. At 8:20 the respiration suddenly became gasping and the patient was cyanotic. The pulse was perceptible but poor in quality. This developed into a condition wherein it was impossible to hear the heart beat with the aid of a stethescope. Two cc. of coramine were administered by hypodermic. The patient took a couple of gasping breaths. At 8:30 the attending physician pronounced him dead.

Laboratory studies made during this illness include:

1. The blood: Microscopic study of the blood revealed: R.B.C., 4,730,000; W.B.C., 6,500; hb, 13.5 gms. or 93 percent; Differential: polymorphonuclears 84, lymphocytes 16; Schilling, count 100, juveniles 1, staffs 5, segs. 78, lymphs. 16.

2. Urinalysis disclosed a clear amber fluid, acid in reaction. The specific gravity was 1026. Neither albumin nor sugar was present. Five or six W.B.C. per H.P.F. were found. An occasional red cell per H.P.F. was observed. Many granular casts were seen.

3. Spinal fluid: A 5 cc. specimen was examined. It was clear. The Pandy was positive. The total protein was 57 mg. percent. The W.B.C. was 111, lymphs .95 percent.

Standing orders[6] for 3-17 included: diet as tolerated; bed rest; demerol 10 mg. 2 Q H or as needed; restraint if necessary; modified isolation technique; two special nurses; watch for signs of rabies; and in the afternoon stop demerol and substitute elixir of phenobarbital drams. 1 Q 4 H. Standing orders for 3-18-50: At 3:05 A.M. sodium amytal grs. 3 "O" stat, ice cap to head. Increase elixir of phenobarbital to drams. 2 Q 4 H. Soft diet, no meats, fluids. Chloromycetin 250 mg. "O" per Q 3 H. Isolation technique. Penicillin 1 cc. duracillin fortified Q 12 H intramuscularly. Benadryl 3 cc. Q 6 H intramuscularly. 2000 cc. 5 percent glucose in normal salt stat. Sodium luminal grs. 5 Q 4-6 H p.r.n. Paredrine sulfathiazole nose drops p.r.n. Codeine grs. 1½ hypo stat. 5:00 P.M. paraldehyde 10 cc. deep-intramuscularly stat. 6:30 P.M. paraldehyde 5-10 cc. Q 2 H to 4 H p.r.n. Oxygen tent. Discontinue luminal. Benadryl 5 cc. stat.

AUTOPSY

Autopsy was performed one hour after death, before the onset of rigor mortis. External inspection revealed the body of a well developed, well nourished white male, 180 cm. in length and weighing 85 Kg. There were abrasions on the skin of the tibial surfaces of the lower third of both legs. These were brown in color and had a fresh appearance. Two healed scars were observed in the palm of the left hand. One of these was 8 cm. and the other 6 cm. in length. The two had a "V" configuration.

The small blood vessels in the arachnoid were injected. The brain weighed 1,435 gms. There was some injection of the superficial blood vessels. Sections appeared normal to the naked eye. Impression smears from the region of the hippocampi, the cerebellum and the cerebellar cortex were fixed in methyl alcohol, dried and stained with Van Geisen's stain. No Negri bodies were identified.

The glomerular tufts of the kidney were engorged with blood and there was a moderate degree of cloudy swelling of the tubular epithelium. Microscopically, the prostate was normal. Repeated search of fresh impressions of the hippocampus, the cerebellum, and the cerebral cortex stained with Van Geisen's stain were negative for Negri bodies.

Hematoxylin and eosin stains of fixed section disclosed:

1. Cerebral cortex: A slight amount of extravasated eosinophilic material, presumably fluid, in the subarachnoid space. There was a slight extravasation of blood.

2. Basal ganglia: Vascular engorgement, definite perivascular lymphocytic cuffing, marked degeneration of large ganglion cells, minute parenchymal hemorrhages, accumulations of lymphocytes and a few polymorphonuclear leukocytes consistent with Babes nodules. Demyelination of the white matter and degeneration of the axis cylinders were not observed.

The pathologist concluded "These findings appear to be consistent with the histologic changes of rabies. The fact that Negri bodies were not demonstrated does not detract from this conclusion. Beatties and Dickson state that Negri bodies are demonstrable in human cases of rabies in only 30 percent of the cases."

After the autopsy Doctor S. fixed the brain in formalin. Fixed tissues are not examined for Negri bodies at the Indiana State Board of Health. However, samples of spinal fluid submitted by Doctor S. were injected into fifteen mice. Three mice killed on the seventh day after inoculation were negative for evidence of rabies. At the end of twenty-one days the remaining twelve were active and well. It was decided to let them live and observe them for evidence of rabies. However, it was concluded the test should be regarded as negative for evidence of rabies. Since this was an unorthodox test, a significant result was not anticipated.

The history of the case, the symptoms, the chronological list of events were the basis for diagnosis. Analysis of all these data suggested to the personnel of the State Board of Health that Mr. C's death was due to rabies and not to post-treatment encephalomyelitis. This opinion is apparently in accord with the final diagnosis of the attending physician, the local pathologist and consultants of the State Board of Health. This conclusion motivated the suggestion that the program for rabies control in Indiana should be intensified. During

1949 a brochure[7] outlining details of an effective program was distributed to all physicians and health officers in Indiana. Attention is respectfully directed to this program. Rabies can develop in spite of a good local program. Hence, an effective program should be no less than state-wide; better still, nation-wide.

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A FULL TERM ABDOMINAL PREGNANCY WITH DELIVERY OF A LIVING CHILD

E. L. C. Broomes, M.D.

EAST CHICAGO

ALTHOUGH the delivery of a full term living baby of an abdominal pregnancy is still a rare enough occurrence to justify its being regarded as a medical curiosity, this case is presented only because of the interesting history, signs and symptoms of the patient, which, considered in retrospect, should have been suggestive enough to indicate the true condition, if the possibility of a progrssive ectopic pregnancy had been kept in mind.

The patient, who is of petite build and weighs about 90 pounds, was first seen March 30, 1948. She had had a sudden attack of severe pains in the right abdominal quadrant, and had fainted on attempting to stand up.

Patient admitted that her last menses had lasted only two days instead of the usual four days. After examination a diagnosis of a ruptured ectopic pregnancy was made. Patient was immediately hospitalized. The diagnosis was confirmed at operation, and a ruptured right tube and a hemorrhaging right ovary were removed. The appendix was also removed at this time. Patient had an uneventful recovery.

Patient was next seen at her home in July, 1949. She was lying in bed complaining of severe abdominal pains which began suddenly while she was dancing. These pains radiated down her left leg, and caused severe cramps. She complained of dizziness, and admitted fainting while going to the lavatory. She denied the possibility of pregnancy, and maintained that she had no recent abnormal menses, and added that she had been married only one week. (Several months later, patient admitted that she really did not menstruate either in July or in June, but was afraid of a second operation at that time.)

Physical examination done at this time was unsatisfactory, and because of the conflicting menstrual history, it was decided to treat the patient conservatively. She was ordered to bed, given demerol 100 mg., an ice bag was placed over her abdomen, and 300,000 units of penicillin were administered. Her relatives were advised to notify the physician if her condition grew worse.

The following day the patient was reported as feeling improved. During the next three months patient was examined and treated by several other physicians for dizziness, weakness, persistent pains in the left lower abdominal quadrant, and cramps in the left thigh and legs. She was hospitalized on one occasion, August 16, 1949, and treated for peritonitis and severe secondary anemia complicating a pregnancy, which was calculated to be in the fourth month.

An x-ray taken at this time, August 26, 1949, was reported as showing a mass, probably fetal, lying to the right of the midline.

After resuming the prenatal care of patient in October, 1949, it was noted that patient complained frequently of pains in the chest, easy fatigability, and some difficulty in breathing freely, especially on climbing stairs. She also complained of violent fetal movements, which often prevented her from sleeping. However, patient approached term without any mishap. About twenty hours before hospitalization she began to complain of severe abdominal pains, which at the time of the first examination recurred every fifteen minutes. Subsequent rectal examinations failed to show any

dilatation of the cervix despite the growing frequency of the pains.

Patient was hospitalized March 1, 1950, at 11 P.M. Eight hours later in spite of strong abdominal contractions and pains which were recurring at short intervals, there was no evidence of progress. An x-ray of the abdomen, with internal pelvimetry, was requested. This revealed a generally contracted pelvis with a fairly large fetus which was apparently at term.

An obstetrical consultation was obtained, and an immediate section was advised. Patient was typed and cross-matched and suitable blood was made available in the operating room.

Under spinal anesthesia, the previous right paramedian scar was excised, and the abdomen was entered through this incision.

A dark bluish, glistening sac, occupying the center of the cavity, was noted. Several large tortuous vessels could be seen on its surface. At the base, towards the pelvis, could be plainly seen the black hair of the fetus. This abnormal transparency was noted, but the true significance was still not suspected. The idea that this might not have been a uterine pregnancy was not even considered at this time. Attempts to identify the bladder, in order that the plica could be pushed back for the contemplated low cervical incision, was unsuccessful. In attempting to find a cleavage plane, the thin sac was pierced; immediately there was a profuse bleeding. Attempts to control this by clamping produced more hemorrhage at other sites, since the clamps merely cut through the tissues, which were very friable. It was decided to deliver the baby by the quickest possible method. The rent at the base was enlarged, the hand was inserted, the head of the baby was brought out of the sac, and the baby lifted out. The cord was clamped and cut. The infant cried vigorously at birth.

Even up to this time, it was not realized that the uterus was not involved. Pituitrin was injected into the wall of the sac, and warm sponges packed in the cavity for hemostasis. As the bleeding subsided, the sponges were removed, and attempts were made to remove the placenta. No cleavage plane could be found. It was at this time, while exploring the attachments of the placenta, that a small uterus compatible to a two month pregnancy was found in the pelvis. The true condition was now apparent. The placenta was seen to be attached to the ileum, the transverse colon, the descending colon, left wall of the pertitoneum, the broad ligament on the left and the ruptured tube.

Since the condition of the patient was good, and the blood loss was being compensated by the transfusion, it was decided to remove the placenta. This was done. The entire placental mass was removed without perforating the intestines. A few denudations of the serosa of the colon, where the placenta had been intimately attached, were repaired. The left tube, which was fragmentary, was removed. The abdomen was closed without drainage, and the patient was returned to the ward.

Instead of the anticipated stormy convalescence, patient had an uneventful postoperative course. She was discharged from the hospital on the fifth day. Sutures were removed on the ninth day, and she was well enough to attend a medical staff meeting on the twentieth postoperative day, at which time her case was presented to the staff.

The infant, which at birth weighed seven pounds four ounces, and had cried vigorously, appeared normal in every respect during the first twenty hours of life; then it suddenly began to show evidence of asphyxia. Oxygen was administered. A pediatric consultation was obtained, but despite all efforts the child died after four hours. Autopsy failed to show any anatomical cause of death.

A review of the available literature shows that according to Beck,[1] between 1809 and 1919 there were only 262 authenticated cases of extrauterine pregnancies with living fetus which had survived the fifth month.

Blond and Montgomery[2] collected reports on 321 cases of full term abdominal pregnancies with a viable fetus for the years 1813 to 1938. They reported a maternal mortality of 40 percent and a fetal mortality of 50 percent. The majority of the surviving children showed evidences of some abnormality, although several attained normal adulthood.

Hellman and Simon collected from all available sources records of 316 cases. Of this number 158 fetuses were considered as viable and 101 mothers died. There were only 80 cases in which both mother and child survived, and of this number there were only 30 cases in which there was demonstrable in mother or child no evidence of neurological or mental disturbances.

Between the years 1935 to 1949 this writer could find in the literature reports on only twenty-one cases of abdominal pregnancies from all over the world.[1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11] When the fact is considered that there are nearly 2½ million babies born annually in the United States alone the extreme rarity of the condition can be better appreciated.

In this series eight of the fetuses were already dead at the time of operation. In two cases the infants died within twenty-four hours of birth. Of the remaining infants two showed evidences of neurological disturbances. There were five maternal deaths. There were only five cases in which both mother and child survived.

The treatment of the placenta varied. There were three cases in which total removal was attempted. In six instances the placenta was marsupialized, the cavity packed, and the abdomen drained. In the remaining cases no attempts were made to dislodge the placenta. The abdomen was closed without drainage.

In the first group no deaths were reported. One case required a second operation for a persistently draining sinus. Average duration of hospitalization was three weeks. There was one live child. In the second group there were four instances in which patients had to be readmitted to the hospital for surgical treatments of complications. There were three maternal deaths. The average hospital stay was four weeks.

In the twelve cases in which the placenta was left intact and in situ, there were six stormy postoperative courses. Reoperation was necessary in three cases. There were three maternal deaths. The average duration of hospitalization was four weeks.

It is obvious that because of the small number of cases treated and reported, and also since complicating factors and conditions varied even preoperatively in each individual instance, the above figures must be considered as meaningless or at least as inconclusive in trying to evaluate the various methods of treating the placenta.

In any discussion on abdominal pregnancy, almost invariably two questions will be raised which can be depended on to provide food for discussion. These are:

1. The probability of an abdominal pregnancy being a primary condition.
2. The best method of treating the placenta.

Whether abdominal pregnancy ever follows the primary implantation of an extragenitally fertilized ovum, or whether the mechanism is based always on the rupture of a tubal pregnancy, followed by a secondary implantation and nidation of the expelled embryo on some favorable nidus in some neighboring viscera, is of course only of academic importance.

Nevertheless, the speculation raises an interesting issue; is the nidation of a fertilized ovum on nonmullerian tissues possible? It should be kept in mind that the syncytiotrophoblast of the early embryo, like most undifferentiated cells, is capable of amazing parasitism. Again, the peritoneum, derived from the primitive coelom, has in certain areas a tendency to exhibit enodemetrial-like differentiation. Because of this metaplastic, or as some would prefer, prozoplastic behavior, it might be conceded that there could be areas in the peritoneum possessing the cellular characteristics of the endometrium on which the active trophoblast of an extragenitally conceived embryo might effect favorable nidation.

In spite of the plausibility of this idea, it is doubtful whether this question would ever be definitely settled as far as the human is concerned. As to the treatment of the placenta there should be less room for disagreement. To attempt any manipulation when the surgical risk is poor, except as it is absolutely necessary for the immediate conservation of life, or to effect any maneuver in which the attending hazard is greater than noninterference, is to be culpable of gross surgical indiscretion.

The present-day tendency is to regard the placenta as an innocuous autogenous mass which is readily absorbable in the abdomen and therefore could be left in situ.

There are accumulating in the literature enough convincing reports to support this view. Nevertheless, it must be kept in mind that in the abdomen the placenta is a foreign body, and has all the potentialities of such. A review of the cases treated and published between 1935 and 1949, in which the placenta was left in the abdomen, showed that at least 40 percent developed abdominal sinuses or peritonitis. There was one case of intestinal obstruction.

Nicodemus,[10] Lull,[2] Bland and Montgomery report instances in which a second operation had to be done to remove unabsorbed placental tissues. In one instance, fifty-six days after the first laparotomy, the placenta, far from being absorbed, had become vascularized and was hemorrhaging.

Perhaps the policy of choice should be to treat each individual case as the particular circumstances would determine. Since the decision whether to drain or not is usually determined by the immediate conditions at surgery, the question of whether or not to remove the placenta should only be decided at the table. From a study of the postoperative complications in the literature examined, it is evident that the placenta is not always an innocuous mass. It is not always readily absorbed. Not infrequently it has been directly responsible for disturbing sequelae. Based on these facts, a justifiable conclusion would be that the placenta should be removed, whenever this can be done without compromising the safety of the patient.

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NATIONAL HEART WEEK

THE INDIANA HEART FOUNDATION is celebrating its second birthday anniversary this month. Its second year of activity has been a highly successful one, and merits the congratulations of the medical profession.

In connection with the observance of National Heart Week special attention is directed to the postgraduate educational program which has been organized by the cooperative efforts of the Foundation, The Indiana State Medical Association and Indiana University School of Medicine.

On the evening of February 6, the fourth of the first series of telephone postgraduate seminars will be devoted to a symposium type of program on diseases of the heart and circulation. This presentation will be transmitted to 19 county medical societies of Indiana by leased wire, and will have as its faculty some of the nation's most noted clinicians and cardiologists. This will mark the first time that the essayists of the telephone seminar will speak from points outside the state.

The symposium program on diseases of the heart and circulation, which is customarily held at Indiana University School of Medicine during Heart Week, will be postponed this year because of the special emphasis on cardiology which the February 6 telephone seminar will carry. The Medical School and the Indiana Heart Foundation are planning to arrange for the regular one-day meeting later in the year.

All the activities of Heart Week in Indiana provide a fitting climax to a year of service on the part of the Indiana Heart Foundation. Much diligent work on the part of its membership and officers during 1950 has resulted in a most gratifying increase in membership and has enabled the Foundation to furnish financial aid to its increasing research and educational programs.

Almost 800 million units of penicillin have been furnished by the Foundation's Penicillin Fund for the treatment of subacute bacterial endocarditis in patients who were unable to purchase the large doses needed for this purpose.

LIFE INSURANCE MEDICAL RESEARCH FUND

IN 1945 a group of life insurance companies of United States and Canada established the Life Insurance Medical Research Fund. Today 146 companies, whose combined business exceeds 90 percent of the total life insurance in force, are supporting the Fund.

Research problems supported by the Fund are chosen with a view to prolonging life expectancy. At present fundamental research on diseases of the heart and circulatory system is being supported.

The fifth Annual Report of the Fund has just been released. It covers an 18-months period ending June 1, 1950, and outlines the investigative programs which were active during that time.

Since its inception the Fund has contributed more than three million dollars to research. Its annual budget now is three-quarters of a million. Over 600 articles have been published as a result of the work that has been made possible by this money.

The institutions which have sheltered the projects number eighty, and are located in thirty-three states, four Canadian provinces, and two foreign countries. In 1950-51 support will be actively given to seventy-eight research programs and thirty-three fellowships.

Emphasis is being placed on fundamental research as a means toward developing adequate preventive and curative knowledge. Arteriosclerosis, vascular hypertension and rheumatic fever are the three diseases which are receiving the major portion of the investigative attention.

In the five years of the Fund's activity, much fundamental knowledge has been acquired. Many new avenues of inquiry have been opened. With the continuation of such research, privately endowed and carefully administered, practical advances in the prevention and treatment of cardiovascular disease may be expected in the future.

SOCIALIZED MEDICINE

THINGS are looking up, but there is still room for improvement.

The elections last fall indicated a trend in public opinion away from socialistic schemes. However, it was a trend and not a total victory. The efforts of those who seek to place the practice of medicine under governmental control will be continued. No one in the medical profession should regard the election results as more than an encouragement that our cause is right and that we have a large number of American citizens on our side.

The 1951 objectives of the A.M.A. National Education Campaign were outlined recently by Mr. Clem Whitaker, the Campaign Director. He pointed out that the upward turn of events now makes possible the accomplishment of many tasks which were postponed necessarily during the early part of the fight to preserve free medicine.

One of our most important tasks is to acquaint labor organizations with the necessity of maintaining a really American system of medical practice. Mr. Whitaker spoke at length on this subject immediately preceding the reading of the address written by Mr. William L. Hutcheson, president of the United Brotherhood of Carpenters and Joiners of America.

"There *is* enlightened leadership in labor which has no intention of following Washington bureaucrats and socializers down the dead-end street which leads to regimented serfdom.

"And there are many in organized labor who are wholly out of sympathy with the ruthless campaign of hate which has been conducted against the medical profession."

The A. F. of L. unions of Camden, Arkansas, published a full page of advertising in support of the doctors during the A.M.A. advertising program. Mr. Whitaker emphasizes this as "an impressive indication of the grass roots labor support which medicine can win when doctors take the facts to the members of their local unions."

The PTA, the League of Women Voters, the American Association of University Women and the nurses' associations were mentioned as groups upon which the socializers are hard at work. Action by these groups will be taken as a result of opinion in the local units. This is where work by doctors and by doctors' wives will count.

Socialization of the legal profession is developing in Great Britain, and there are indications of the same thing in this country. Now is the time for the medical and legal professions to develop an even closer relationship, and to cooperate fully.

Finally, Mr. Whitaker stressed the necessity of broadening the program of Voluntary Health Insurance. Even though its growth has been spectacular, "the objective of the medical and hospital care plans—and the indemnity plans of the accident and health insurance companies—should be to expand their coverage until all the people of this country who need budget-basis medicine can secure it, at a price they can afford to pay."

In conclusion—"Most of all, every doctor needs to recognize that it isn't enough any more just to be a good doctor, if you want to remain a free doctor. It requires also being an alert, aggressive citizen, ready to defend what America has given us."

AMA ADVERTISING CAMPAIGN

ONE OF THE advantages of adversity is that it locates your friends. The medical profession, during the past few years, has been through adverse conditions in connection with attempts to establish socialized medicine in this country. One of the most heartening things about our trials and tribulations has been the discovery of a host of friends.

Early in the AMA National Education Campaign it was evident that the doctors would not have to fight the threat of government medicine by themselves. With the development of the campaign this fact became more and more evident.

When the AMA encouraged the enactment of resolutions against socialized medicine it was surprising how many lay organizations of all sorts "stood up and were counted." Resolutions from every part of the United States have come from organizations of all types and sizes and have now exceeded the number of 10,388.

The nation-wide advertising program of the AMA has again demonstrated the widespread support with which the cause of free medicine has been blessed. The report made by Miss Leone Baxter, General Manager of the National Education Campaign, in Cleveland, is ample testimony.

"Never before has one profession, business or industry found thousands of unrelated groups, in virtually every area of the country, coming forward to its defense. More than 65,000 businesses, organizations and individuals bought space in their local papers to state their views, to take their public stand with medicine, and to spend two million dollars of their own money to do it.

"This support did not come from 'big business' and 'reactionary interests' as Mr. Oscar Ewing recently proclaimed it would. It came, with real grass roots strength, from tens of thousands of small advertisers along the Main Streets of America—from drug stores, groceries, dairies, hardware stores, insurance agents, banks, movies, utilities, churches, medical care plans, dry goods stores, hospitals and clinics, restaurants, laundries and plumbers."

This is a response which imposes a great responsibility on the medical profession. Confidence such as this is deeply appreciated, and it must be justified by continuing efforts on our part to maintain our practice at its present high standards and to improve on it at every opportunity.

Letter to the Editor

Connersville, Ind., Dec. 12, 1950.

Dear Editor:

In the December issue of *The Journal of the Indiana State Medical Association*, page 1222, you have an article "A Minister Speaks Out." I note what you say in regard to having little contact with ministers and little knowledge perhaps of the stand toward "socialized medicine."

Since I am an ordained minister and have spent nearly five years in the foreign mission field and several years in the ministry before going there, I am replying to that article.

First of all, I agree with this man 100 percent, but would like to add that he is an exception rather than the rule in what we call the Federal Council of Churches of America.

If you will look in Flynn's book, "The Road Ahead," you will find one chapter given over to the teachings of this group. I thought perhaps I could help clear up matters with this letter. First, the Federal Council of Churches is made up mostly of modernistic ministers who do not believe the fundamentals of the Christian faith but lean more toward Communism and Socialism than to our American way of living.

The Federal Council of Churches is 100 percent for Socialism and "socialized medicine" as a whole; whereas the American Council of Churches opposes the Federal Council of Churches stand and believes that our way of living is far superior to any in any other part of the world. So we find that the American Council of Churches is the one that is upholding the American way of living—including medicine as we now have it; whereas the other group is working against our present government and medical system.

I am enclosing a short clipping from a paper,* one of the many I have in my possession, bearing this out. The Federal Council, because of the pressure brought to bear on them, have recently changed its name to National Council, but it is the same old group under a different name.

Another article to verify what I have said is in the September issue of *The Reader's Digest*, "Let the Church Speak Up for Capitalism."

Sincerely yours,
C. L. ENTNER, M.D.

* Not published here.

President's Page

SURVIVAL IF WE ARE FIT

FOR SEVERAL YEARS the specter of mad Russia has been hovering over us and we have been reluctant to admit it. When the Iron Curtain was run down, shutting us off from what went on behind, the war of nerves was on. So long as they remained passive, we could comfort ourselves by saying it would end happily somehow. But their conduct in Germany began to make us nervous and suspicious. Their infiltration into our Government and various phases of our national life made us know they were serious. The war in Korea now leaves no doubt of their plan to take what they want. For these many years their actions have served to drain our treasury of enormous sums. There is a limit to our treasury—to any treasury. And now they are being allowed to kill our boys. Our worst fears are being materialized.

The dread of what has been going on behind the Iron Curtain is becoming more real and frightening every day. After all, a nation which operates behind an Iron Curtain can have but evil in its mind. Our naive hopes that all would come out all right somehow, are beginning to change to a sickening, stunning realization that they are playing for keeps. Our very lives are now in jeopardy. We might as well take stock and admit it. For too long we have hoped against hope. Not only is America facing its greatest crisis, but civilization as we know it may well be headed for destruction. Other civilizations have fallen. The day for ours may be here.

The time has passed for any citizen to hinder the defense of this country in any way. The time has come when every citizen must think and work unselfishly for his country's welfare. We can still retain our opinions as to how our affairs have been conducted, but it is too late to rock the boat now. We must close ranks and present a solid front in an effort to survive. This test will require the earnest effort of every one of us. There will be sacrifices necessary by many that we do not like to think about.

Physicians, especially, will carry heavy burdens. If the atom bomb is used the role of civilian doctors will be of utmost importance. The number of medical personnel which the contemplated army will require will cause a real shortage of doctors on the home front. Each of us must turn in his best job and uphold the fine tradition which has been passed along to us.

Hard days are ahead, but with right on our side, **and if we are strong enough,** we will surely win. We **must** win.

Alfred Edison

Medical Panorama by the Associate Editor

How to Act Before a Judge

If there is any one facet of the complete jewel of our discipline in regard to which most of us ordinary doctors are apt to be found wanting, it is forensic medicine. The subject is usually conceived of as forbidding and we are thus easily persuaded to assume we will not need it, anyway. At long last, it is our happy privilege to quote from an article on "The Doctor in Court," written by a lawyer, Hearst R. Duncan, LL.B., of Des Moines, without technical legal phraseology, and published in the December, 1950 *Journal of the Iowa State Medical Society*. He begins by recognizing the general attitude of doctors:

It is a sincere pleasure to have this opportunity of addressing the Iowa State Medical Society, but frankness compels me to add that this pleasure is somewhat dimmed by the realization that my topic concerns a situation which the average doctor thoroughly dislikes. Nevertheless, the doctor has gone to court at least 700 years as an expert witness in steadily increasing numbers so that, distasteful or otherwise, it has become a duty linked with his profession that must be manfully, if not happily, faced.

In this era of emphasis on public relations, surely the sad spectacle of contradictory and partisan testimony by "medical experts," in too many instances, offers a golden opportunity for a little housecleaning on our part. To-wit:

Expert testimony, of course, is more than a recitation of scientific facts and conclusions. Like every act, it has its own skill and technic. An ordinary witness can testify only to what he sees or hears. He cannot state any opinion or conclusion. The expert, on the other hand, is given a wide latitude. He gives conclusions and opinions, nay even dissertations on the subject at hand. He is a teacher called to instruct the court and jury on a scientific matter on which they presumably and almost invariably have no knowledge.

To be effective, as a teacher, he must translate medical terms into the layman's language. In explaining an injury or bodily process he must use simple everyday illustrations. If he does not do this, his testimony is valueless, regardless of its accuracy. Too often the doctor seems to feel that his knowledge and skill is on trial and unconsciously, perhaps, uses scientific terminology which would be eminently fitting in a medical clinic, but which leave a jury and court in a state of complete bewilderment. Certain members of the legal profession are accessories to this unfortunate occurrence.

And in conclusion Mr. Duncan gives a summary which we all well might clip for future reference, to be mentally imbibed and thoroughly absorbed before entering a courtroom:

I believe everything of value in these remarks can be summed up as follows:

1. A doctor should regard medical testimony as a duty.

2. A doctor should testify only on those matters for which his training and experience qualify him.

3. A doctor should be as fair and impartial as the trial judge, and should never favor a litigant.

4. A doctor should understand the necessity and purpose of cross examination and never permit hostility to influence his answers.

5. And last but certainly not least, if a doctor does not know the answer to a given question, he should frankly say so.

The trick is, to *remember* these principles when the cross-examiner turns on the heat. As for us, we're going to paste them in our hat.

Reading Time: Two Minutes

We hear and read much about medical economics, especially on the state and national scale, but little is said about the very first link in the chain—the doctor (one doctor) and his patient (the one he is concerned with at any given time). Committees have been established to iron out grievances, usually regarding fees, but such complaints are better prevented, than cured.

New York Medicine, for October 20, 1950, contains an editorial on the subject of fees which begins by emphasizing the fact that the "index" of physicians' fees is considerably lower than the General Consumers' Price Index. It then discusses prevention of delinquent accounts, as follows:

Prevention means having a clear financial understanding with the patient *before* treatment. This requires tact. Remember that 98 per cent of the time you are dealing with an honest, sincere person who expects to pay for your services. Give him a chance to introduce the subject of fees—don't brush off a timorous query of "How much, doctor?" with an "Oh, let's not worry about that now. You just get well."

Keep in mind that he had to muster up a lot of courage to ask that question, and he is entitled to both a fee estimate and an explanation. After all, you are not ashamed of your fees, and, in asking this question, the patient doesn't realize that you're just as self-conscious about talking fees face to face with him as he is, and that you would much prefer to sidestep the responsibility and later let your statement break the news.

To clarify the understanding of fees, it is your duty to give details such as a reasonable prognosis and explanation of the treatment, the knowledge of the patient's ability to pay and specific methods of payment within his means. To prevent any misunderstanding, clarify the patient's responsibility to pay for other services, such as laboratory, consultant, assistant, x-ray, anesthesia and hospital charges.

These are words of wisdom and will stand up under analysis, because in working out these ideas the author has tried to view the problem through the eyes of the patient. And what patient can fret about a doctor who "sees eye to eye" with him?

As corollary to this theorem, imagine yourself about to consult a lawyer. Wouldn't you then like to have just a little idea of what you are getting into as to fees, court costs, etc.?

Q. E. D.

INDIANA'S PLAN FOR HEALTH SERVICES IN CIVIL DEFENSE

L. E. Burney, M.D.*

George M. Brother, M.D.**

INDIANAPOLIS

"THE CIVIL DEFENSE program for this country must be in constant readiness because for the first time in 136 years an enemy has the power to attack our cities in strong force, and for the first time in our history that attack may come suddenly, with little or no warning.

"Granted a few minutes warning, casualties could be reduced by over 50 percent through proper organization and training in civil defense. More important, civil defense could spell the difference between defeat with slavery for our people and victory in a war thrust upon us."[1]

This warning presents to each of us a challenge which must be met and a duty that must be assumed. It is a special challenge to the medical and allied professional groups who because of their special skill, training and experience, will fulfill such a vital role in the health services phase of a broad civil defense program. The present international tension mandates a "stepping up" of our plans for civil defense from a relative stand-by status to an operational basis, paralleling military and industrial mobilization.

Direction of the national civil defense was formerly a function of the Department of Defense; later (1949) this responsibility was transferred to the National Security Resources Board. During 1950, the continuous expansion of the program prompted the 81st Congress to create a Civil Defense Administration, giving its administrator broad powers to prepare for an emergency. On December 6, 1950, Millard F. Caldwell (former Governor of Florida) was appointed Director of F.C.D.A. One of the first publications of F.C.D.A. was a guidebook on Health Services Planning.

The Indiana Department of Civil Defense was created and its powers and duties established by Chapter 275 of the Acts of 1949. Under this act, the Governor is responsible for the general direction and control of the civil defense agency. The Superintendent of State Police becomes, by virtue of his office, the director of civil defense under the Governor. The act further stipulates that the Governor "shall be assisted by a Civil Defense Advisory Council. . . . The Council shall advise the Governor on matters pertaining to civil defense."

The Civil Defense Advisory Council, appointed by Governor Schricker and of which he is chairman, includes the Executive Branch of the State Government, the Superintendent of Maintenance of the State Highway Commission, the Secretary and Commissioner of the State Board of Health, the State Fire Marshal, the Director of Public Welfare, and the Adjutant General. The States Relations Officer of the American Red Cross, the Director of the Indiana Economic Council, and members of the Indiana State Police Board are ex-officio members.

Early in its existence, the Advisory Council prepared the Indiana Disaster Plan, which describes in detail the functions of the Civil Defense Department under the law, defines terms, outlines procedures and charts the overall organization of the department and the specific responsibilities assigned to each division. The responsibilities delegated to the various divisions are based upon the definition of "civil defense" in the law itself which reads:

"These functions shall include, without limitations, fire fighting services, police services, medical and health services, rescue, engineering, air raid warning, communications, radiological services, evacuation of persons from stricken areas, emergency welfare services (civilian war aid), emergency transportation, existing or properly assigned functions of plant protection, temporary restoration of public utility services, and other functions related to civilian protection together with all other activities necessary or incidental to the preparation for and carrying out of the foregoing functions." The assumption is clear that civil defense is a responsibility of civilians and their civil governments.

Governor Henry F. Schricker directed that the State Board of Health assume responsibility for planning and administering the Health Services and Special Weapons Defense phases of the civil defense with the State Health Commissioner to serve as director. With the assistance of representatives of the medical and allied professional groups, the objectives, functions and organization of Health Services in Indiana have been established and plans developed to place the program on an operational basis in Indiana.

The objectives of this division are as follows:

1. To minimize the casualties and suffering

* Director, Indiana Civil Defense Health Services.
** Deputy Director, Indiana Civil Defense Health Services.

[1] United States Civil Defense.

which would result from atomic or other possible forms of warfare.

2. To insure the most effective use of health and medical resources available for the protection of the citizens of Indiana in natural and unnatural disasters.

3. To work with and assist local communities in the development of civilian defense health and medical services with the full appreciation that the major responsibilities for the effectiveness of this program in Indiana falls upon local areas.

In carrying out these objectives, the State Health and Medical Services Division will:

1. Stimulate and assist local areas to develop the following general services:
   Preventive Medicine
   Environmental Sanitation
   Medical Care (Emergency Medical Services)
   Hospital
   Training
   Public Information
   Blood and Laboratory
   Education

2. Effect a plan of regionalization of the state for the purpose of mutual aid planning by local areas including interstate cooperation.

3. Plan local indoctrination and refresher courses and when necessary, provide guidance and direction for such courses.

4. Plan for and assist in an inventory of human resources, supplies, equipment and facilities related to the previously mentioned functions and the cataloging of this information.

5. Coordinate plans for stock-piling of supplies and equipment and for their disbursement.

6. Keep the public informed relative to the health and medical aspects of civil defense through (a) newspapers, radio and similar media; (b) the provision of educational and informational material such as pamphlets, films and similar materials.

FUNCTIONS OF THE BRANCHES OF HEALTH AND MEDICAL SERVICES DIVISION INDIANA DEPARTMENT OF CIVIL DEFENSE

Preventive Medicine Branch

Louis W. Spolyar, M.D., Chairman
Andrew C. Offutt, M.D., Deputy Chairman
- Communicable Disease Control
- Vital Statistics and Mortuary Services
- Veterinary Medicine
- Industrial Health
- Nutrition
- Biological Defense

Environmental Sanitation Branch

B. A. Poole, Chairman
Tim Sullivan, Deputy Chairman
- Water and Sewage
- Food, Milk and Drugs
- General Sanitation
- Radiological and Chemical Defense

Blood and Laboratory Branch

Clyde G. Culbertson, M.D., Chairman
J. L. Arbogast, M.D., Deputy Chairman

Medical Care Services Branch

Glen Ward Lee, M.D., Chairman
James M. Leffel, M.D., Deputy Chairman
- Emergency and Normal Medical and Nursing Care

Hospital and Supply Branch

Martha O'Malley, M.D., Chairman
Charles Myers, M.D., Deputy Chairman
- Hospitals and Casualty Stations
- Supplies, Drugs, Biologics, and all others
- Evacuation and Ambulance Service
- Pharmaceutical Services

Training Branch

Donald Caseley, M.D., Chairman
Samuel H. Hopper, Ph.D., Deputy Chairman

Education Branch

Robert Yoho, Chairman
- Educational Materials
- Activities in the School
- Community Activities of the School Personnel

Public Information Branch

James Carr, Chairman
Michael McCaffrey, Deputy Chairman
- Source of Information to the Public
- Preparation and Editing of Information Material
- Liaison with Press, Radio and Other Educational Media
- Liaison and Coordination with Other Branches of the Division and Other Divisions

"Most civil defense health workers will be civilians working on a voluntary basis and, for some of them, legal authorization to participate must be provided by civil government. Civil Defense Health Services should be administered by existing civil-health authorities, under supervision of civil defense directors. The health service should be an extension of existing services rather than a separately administered organization which inevitably would duplicate the work of, and compete with, existing legally authorized health agencies. Such an arrangement would, in itself, assure a considerable degree of uniformity."[1]

No single function in the health services can operate effectively in a vacuum, in a compartment all by itself. The varied functions are interrelated

[1] United States Civil Defense, Health Services and Special Weapons Defense.

from the provision of medical care to the protection of food, milk, water and special defense against atomic, radiologic, chemical and biological warfare. Sound planning requires mutual understanding of the skills and experiences each group has to offer. Effective operation necessitates integration and the fullest of cooperation and assistance.

The same principle applies within the broader scope of the civil defense organization, state and local. Health services cannot operate alone, isolated from the other civil defense services. All must be fully coordinated. Transportation of health personnel, supplies and casualties would be seriously hampered without complete coordination between health and transportation services. This points up, too, the necessity for each service within the civil defense organization to understand the functions, organization and responsibilities of all others.

It is most important that local communities plan and establish their own civil defense programs. If enemy attacks come, they in all probability will be against highly selected, local communities with prime industrial targets. In such dire eventuality, it will be up to neighboring communities to come to their aid. Thus all communities must be protected.

Several key cities are already well along with their plans under the aegis and stimulation of the local medical societies and their civil defense committees. These groups merit special commendation for their demonstration of community leadership and their unselfish liberal contribution of time and effort. A meeting has been held with the directors of the health services divisions in the five large metropolitan areas that have gone ahead with their planning for the purposes of discussing their programs, exchanging plans and information, and outlining methods for mutual aid. Later, a similar state-wide meeting of all health service directors will be called.

Effective planning and operation of civil defense health services depend greatly upon the leadership and support of volunteers from the medical and allied professional groups. The full understanding and support of state and local societies of the health professions are essential, too, since the professional manpower required for the operation of the health services must come from private ranks. Past experience leaves no doubt that physicians, dentists, nurses, engineers, pharmacists and members of the other health professions will accept these additional responsibilities and discharge them well.

SURGERY AND MEDICINE REMOVE BLIND FROM AID ROLLS

Surgical intervention and medicine are removing thousands from the blind aid list but there is much work yet to be done, according to a Beverly Hills (Calif.) ophthalmologist. Praising the rehabilitation program being carried on in several states, Dr. Alexander R. Irvine said, in the December 23 *Journal of the American Medical Association*, that "noteworthy progress had been made in the last few years."

The importance of rehabilitation of the blind and the need for greater effort in this direction from the standpoint of the patient on one hand and the huge funds necessary for his support on the other were brought out by Dr. Irvine.

"Because of the tremendous increase in the population of the United States and the fact that the span of life has been lengthened 20 years in the last few decades, the blind program has become one of great economic concern to us all," he said.

In most states the blind person receives, on the average, $50 a month, the article explained. The federal government paid over $40,000,000 in 1948-49 to aid the blind. Rehabilitation has saved the taxpayer about $2,000,000 yearly. The National Association for Prevention of Blindness estimates that there are approximately 280,000 blind men, women and children in this country.

"Much could be accomplished if these savings through restoration of vision could be allotted to research associations and institutions for prevention of blindness and the treatment of the blind," Dr. Irvine commented. He noted that less than $1,000,000 a year is being spent in universities and laboratories for eye research.

The "great advances" that were made in the past 50 years in the knowledge of the eye and its diseases were cited by Dr. Irvine to be due to the "development of the ophthalmoscope and the slit lamp, and the progress made in physiology that enables the clinician to correlate his observations with the microscopic changes in diseases affecting the eye."

Of the future he says:

"It becomes apparent that ophthalmology encompasses a field so large that one person cannot hope to cover it, which suggests that in the future specialization will increase. There will probably be more emphasis on and attention paid to group practice, each man within the group having his particular interest and talents, all of which will be necessary to best care for the patient's needs."

Deaths

Lewis W. Tennant, M.D., of Fort Wayne, died after a long illness on December 17, at the age of seventy-nine. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1904, and practiced in Larwill until his retirement in 1946, when he moved to Fort Wayne. He was an honorary member of the Whitley County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Ernest deWolfe Wales, M.D., of Indianapolis, died on December 11, at the age of seventy-seven. He was a graduate of Harvard Medical School, in Boston, in 1899, and had practiced his specialty of otolaryngology in Indianapolis since 1906, until his retirement three years ago. He was a veteran of World War I. Doctor Wales was an Honorary member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Karl C. Eberly, M.D., of Fort Wayne, died on January 8, at the age of sixty-three. A graduate of the University of Michigan Medical School, at Ann Arbor, in 1912, Doctor Eberly served in World War I, and had practiced in Fort Wayne since that time. He was a member of the Allen County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

John J. Connelly, M.D., of Terre Haute, died suddenly on January 12, at the age of fifty-nine. He graduated from the University of Louisville School of Medicine, in Louisville, in 1913. He had practiced in Terre Haute since 1924, specializing in ophthalmology and otolaryngology. Doctor Connelly was a member of the Vigo County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Onis Brendel, M.D., retired physician of Zionsville, died on January 3, at the age of sixty-seven. He was a graduate of the Physio-Medical College of Indiana, in Indianapolis, in 1907, and he had practiced in Indianapolis before moving to Zionsville.

Thomas J. Clutter, M.D., of Mentone, died on December 23. He was seventy-three years of age. A graduate of Rush Medical College, of Chicago, in 1904, he had practiced in Kosciusko County for forty-six years.

Hayes H. Dutton, M.D., of Martinsville, died on December 28, at the age of seventy-four. He graduated from the Central College of Physicians and Surgeons, in Indianapolis, in 1904, and had practiced for more than forty-five years, in Rockport, Paragon, Spencer and Martinsville. Doctor Dutton was a member of the Morgan County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Otis C. Higgins, M.D., of Lebanon, died suddenly on December 26. He was seventy-four years of age. He graduated from the Chicago Homeopathic College, in Chicago, in 1900, and had practiced in Lebanon since that time. Doctor Higgins was a member of the Boone County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Otho R. Lynch, M.D., of Peru, died on December 25, at the Cold Springs Veterans Hospital in Indianapolis, after a long illness. He was seventy years of age. He was a graduate of the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1906, and in addition to practicing in Peru, Doctor Lynch had served as superintendent of the Long Cliff Hospital at Logansport, the Wabash Valley Sanitarium at Lafayette, and the hospitals at Richmond and Madison. He was a veteran of World War I, and a former member of the Tippecanoe County Medical Society, the Indiana State Medical Association, and the American Medical Association.

William O. McKittrick, M.D., of Washington, died on December 19, after a long illness. He was seventy-one years of age. He graduated from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1907, and practiced in Plainville from then until 1925, when he moved to Washington. He was a member of the Daviess-Martin County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Maude Wells McConnell, M.D., retired physician of Sullivan, died on December 19, following a long illness. She graduated from the Medical College of Indiana, in Indianapolis, in 1895, and had practiced in Frankfort and in Indianapolis.

News Notes

Dr. L. M. Hughes, formerly of Paragon, has opened an office for the practice of medicine at 642 Dora Street, in New Smyrna Beach, Florida.

Dr. John W. Beeler is now associated in the practice of radiology with his father, **Dr. Raymond C. Beeler**, and **Dr. James N. Collins**, at 712 Hume-Mansur Building, Indianapolis. Dr. John Beeler just completed three and one-half years of training at the Mayo Clinic.

Dr. Daniel L. Bower, of Indianapolis, is now located in Barboursville, Kentucky.

Captain Thomas A. Stump, of Indianapolis, has been transferred to the 3rd Bomb Wing in the Far East Air Force. He is a graduate of Indiana University School of Medicine, and served his residency at the Marion County Tuberculosis Hospital at Sunnyside before entering the Air Force.

Dr. William F. Hughes, of Indianapolis, announced his retirement from private practice January 1. He has been in the active practice of ophthalmology for forty-five years.

Dr. Frank M. Hall, of Indianapolis, former medical consultant and supervisor for the state Vocational Rehabilitation Division, has been appointed director of the crippled children's service. **Dr. Charles R. Bird**, of Indianapolis, has succeeded Doctor Hall at the rehabilitation office.

Dr. William M. Loehr, of Indianapolis, is now on active duty with the Army, with the rank of lieutenant-colonel. At present he is stationed at Murphy General Hospital in Waltham, Massachusetts, where he is in charge of the department of radiology.

Dr. Norman R. Booher, of Indianapolis, has been appointed a member of the American Legion's National Rehabilitation Committee.

Dr. Robert D. Arnold, of Indianapolis, reports to the Tinker Air Force Base in Oklahoma City, February 7, for active duty. A 1947 graduate of Indiana University School of Medicine, he has been in the practice of obstetrics at 3419 East 10th Street.

Now serving in the Pacific with an LST Division is **Dr. William J. Pierce**, of Indianapolis. He is a lieutenant in the Navy. A 1949 graduate of the Indiana University School of Medicine, Doctor Pierce completed his internship at the St. Vincent's Hospital in Indianapolis.

Dr. Ray Fitch, of Muncie, has been called to active duty with the Air Force. He will report to Chanute Field, Illinois, on February 5.

Dr. John E. Dailey has moved from Terre Haute to Indianapolis, where he has opened an office at 4104 Madison Avenue.

Announcement has been made by **Dr. John F. Jackson** of the opening of an office for the practice of anesthesiology at 617 Forest Avenue, in Fort Wayne. Doctor Jackson is a graduate of the Indiana University School of Medicine, and took specialized training in the field of anesthesia at Indianapolis General Hospital and the Cold Springs Veterans Hospital in Indianapolis. He is a veteran of World War II.

Dr. J. Guy Hoover, Jr., of Boonville, has begun a year's residency at the Minneapolis Veterans Hospital, in Minnesota. Upon completion of the residency, he plans to return to Boonville to resume a practice he has maintained there since 1946, when he was released from military service.

Arrangements have been made for **Dr. J. C. Schubert**, of Cedar Lake, to take over the practice of **Dr. G. D. Larrison**, of Morocco. Doctor Larrison plans to retire.

Two Evansville physicians, **Dr. Howard Neucks** and **Dr. Owen L. Slaughter**, have been ordered to active duty with the Air Force. Dr. Slaughter reported February 1 at Wright Field, Dayton, Ohio, and Dr. Neucks will report to Randolph Field, Texas, March 21.

The Indiana Society of Anesthesiology recently elected **Dr. Charles N. Combs**, of Terre Haute, and **Dr. Floyd T. Romberger**, of Lafayette, to honorary membership in that society.

Dr. Cleon A. Nafe, of Indianapolis, has been appointed to the Board of Trustees of the Indianapolis Foundation for a six year term.

Dr. Sydney L. Stevens is now associated with **Dr. Bert E. Ellis** at 303 Hume Mansur Building, in Indianapolis, in the practice of otolaryngology. Doctor Stevens recently completed a two year residency at Indianapolis General Hospital. He has also had a rhinoplastic course with Dr. Maurice Kottle, in Chicago, and work in allergy with Dr. French Hansel of St. Louis. He is a 1937 graduate of Indiana University School of Medicine, and served for five years in World War II.

TRIBUTE TO DR. J. T. OLIPHANT

Dr. J. T. Oliphant, of Farmersburg, was honored for his forty-five years of service in his community, at a program in the school gymnasium there on January 11. Doctor Oliphant served continuously in that vicinity, with the exception of the time he served as a lieutenant in World War I. He is a past president of the Indiana State Medical Association, and was voted to second place in the selection of General Practitioner of the Year by the A.M.A. two years ago. Dr. Alfred Ellison, president of the Indiana State Medical Association, sent the following telegram to the master of ceremonies of the program: "Farmersburg has been exceedingly fortunate in having Doctor Oliphant, one of Indiana's most beloved and highly respected physicians, practice in its community for these many years. We compliment you for recognizing his faithful service, not only as a physician, but as a citizen and a good neighbor, and join in paying him this well deserved recognition."

CONFERENCE OF TEACHERS OF CLINICAL RADIOLOGY

The eighteenth annual Conference of Teachers of Clinical Radiology will be held in the Red Lacquer Room of the Palmer House, in Chicago, February 10. The subject will be "Radiologic Defense."

CLINICAL CONFERENCE OF THE CHICAGO MEDICAL SOCIETY

The annual Clinical Conference of the Chicago Medical Society will be held March 6, 7, 8 and 9 in the Palmer House, Chicago. Thirty-four outstanding speakers will present half-hour lectures. Another group of authorities will participate in four panels on timely topics.

FELLOWSHIPS IN INDUSTRIAL MEDICINE

The U. S. Atomic Energy Commission will offer four fellowships in industrial medicine for the 1951-52 academic year, continuing a special fellowship program begun last September. The program is administered for the AEC by the Atomic Energy Project of the School of Medicine and Dentistry, University of Rochester, Rochester, N.Y.

The purpose of the special fellowship program is to provide advanced training and on-the-job experience to men and women medical doctors in the field of industrial medicine, particularly in relation to the atomic energy industry.

Applications for the 1951-52 fellowships should be submitted by March 1, 1951 to: A.E.C. Fellowships in Industrial Medicine, Atomic Energy Project, School of Medicine and Dentistry, University of Rochester, Rochester, New York.

INDIANA PSYCHOSOMATIC FORUM

The formation of the Indiana Psychosomatic Forum has been announced. It is held the third Monday of each month, at 8:00 P.M., on the third floor of the Clinic Building, at the Indiana University School of Medicine. Anyone interested in psychosomatic medicine is invited to attend.

POSTGRADUATE COURSE IN PULMONARY DISEASES

A Postgraduate Course in Pulmonary Diseases will be presented at the Marquette University School of Medicine, in Milwaukee, March 26 to 31. This intensive course has been arranged by the Committee on Medical Education of the American Trudeau Society, with the cooperation of the Marquette University School of Medicine and visiting faculty. The course is intended for physicians who have special interest and training in pulmonary diseases. Fee $50.00, payable in full with application. Application should be made before February 15 to the Wisconsin Anti-Tuberculosis Association, 1018 North Jefferson Street, Milwaukee 2.

AMERICAN COLLEGE OF ALLERGISTS

The American College of Allergists will hold its seventh annual meeting at the Edgewater Beach Hotel, Chicago, February 12-13-14, 1951.

This year the College is trying for the first time the experiment of offering its post-collegiate instructional course on the three days just preceding its annual conclave. The course is an extremely practical one designed for any physician who wants to learn the basic principles of diagnosis and treatment of allergic individuals and techniques that are useful in the management of these patients. A fee of $35.00 will be charged for the three-day course lasting through February 9-10-11. For further information and registration write Fred Wittich, M.D., Secretary-Treasurer, American College of Allergists, LaSalle Medical Building, Minneapolis, Minnesota.

THE MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

More than 13,000 doctors of medicine in Michigan and surrounding states are being invited to attend the fifth annual Michigan Postgraduate Clinical Institute to be held in Detroit, March 14-15-16.

The scientific program will be conducted at the Hotel Book-Cadillac where thirty-five outstanding medical teachers and clinicians from all over the nation will offer oral and visual presentations of the newest techniques in the field of medicine and surgery.

HEALTH IN TODAY'S WORLD

The South Bend-Mishawaka Center of Indiana University will present a series of five lectures designed to acquaint the lay person with basic facts about his mind and body, to help him "catch up" on the contribution new drugs have made toward his life expectancy, to clarify the place of the hospital and laboratory in medical care, and to give opportunity for discussion of questions allied to these topics. The series is sponsored by the Rural Health Committee of the Indiana State Medical Association and the St. Joseph County Medical Society, in cooperation with the Center.

The group will meet for five successive Tuesday evenings, beginning February 13. Drs. Raymond E. Nelson, Marshall I. Hewitt, Edward W. Custer, Bernard E. Edwards, and Frank M. Scott, of the St. Joseph County Medical Society, will be the lecturers.

POSTGRADUATE CONVENTION OF COLLEGE OF MEDICAL EVANGELISTS TO BE HELD MARCH 11-16

Diagnosis, Management, and What's New will be the theme of the annual Postgraduate Convention of the College of Medical Evangelists School of Medicine, to be held at the Biltmore Hotel, Los Angeles, March 11-16. It is expected that more than 2,500 physicians and medical leaders from all over the United States and Canada will attend the meetings which are open to graduates of all recognized medical schools.

General Practice Meeting

The six-day medical convention is especially geared to the needs of the general practitioner. Many eminent medical speakers from all parts of the United States will bring practical and comprehensive syntheses of latest advances in medicine which can be put to immediate use. This program has been planned by a committee consisting of both general practitioners and medical school faculty.

Formal credit to those who attend the lectures will be granted toward membership in the American Academy of General Practice. The AAGP convention in San Francisco follows the Postgraduate convention, beginning March 19.

The registration fee for the convention is $10.00 and for the special courses $15.00. For income tax purposes this is an annual convention. Enrollment for the special courses will be by preconvention registration only.

Sponsor of Convention

The Postgraduate Convention is sponsored by the Alumni Association of the College of Medical Evangelists. Dr. Paul D. Foster will be the general chairman.

Further information concerning the convention may be obtained by writing or telephoning Dr. Jerry L. Pettis, Managing Director, White Memorial Hospital, 312 North Boyle Avenue, Los Angeles 33, California.

PRESCRIBED READING: "SANTA CLAUS, M.D."

A new book, "Santa Claus, M.D.," which is just what the doctor ordered for public relations purposes, has been written by Dr. W. W. Bauer, Director of the A.M.A. Bureau of Health Education. Taking a strictly positive approach, Doctor Bauer builds his case for free medicine around the A.M.A.'s 12-point program. Only when the reader is most enthusiastic over the progress achieved under our present system does Doctor Bauer indulge in sly and humorous comments on what would happen under the federal government's plan of compulsory health insurance.

This is a book which you should read yourself, then prescribe for all your lay friends. It can be purchased at local book stores, through the publishers, the Bobbs-Merrill Company, 730 North Meridian Street, Indianapolis 7, or from Dr. George F. Lull, Secretary and General Manager of the A.M.A.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

At a special meeting of the American Board of Obstetrics and Gynecology, held in Pittsburgh, Pennsylvania, December 14, 1950, the following changes in the regulations of the Board were unanimously adopted:

1. That physicians otherwise qualified, who were graduated before January 1, 1939 and whose required training was in obstetrics or gynecology alone, and who have confined their practice to obstetrics or gynecology for at least five (5) years immediately prior to application be accepted for examination as candidates for certification in either obstetrics or gynecology. In all other respects requirements for eligibility remain the same for those physicians graduated since 1939. Bilateral training is required as published in the Bulletin of the Board.

2. Applicants who have been certified by one of the other American Specialty Examining Boards will not be eligible for certification by this Board until they have relinquished the certificate previously conferred.

3. Since the vast majority of obstetrical and gynecological cases are nonoperative the Board requires adequate training in basic sciences, infertility, endocrinology, oncology, irradiation therapy, psychosomatic medicine, electrotherapy, and other nonoperative methods of diagnosis and treatment, as well as training in major operative procedures.

Indiana University News Notes

Occupancy of a recently completed $400,000 research wing adjoining the James Whitcomb Riley hospital for children, is proceeding as rapidly as laboratory equipment is received and installed. Constructed by the state, the building is being equipped from funds secured by the Riley Memorial Association in a state-wide campaign to advance studies of the diseases of children.

Among investigative projects being located in the Research Wing are those dealing with the infectious diseases of children, endocrine balance, nerve regeneration, tumors, cardiac diseases and congenital conditions. The research program is under the supervision of the Indiana University School of Medicine and Medical Center.

Leaders in various fields of cancer study are being brought to the Indiana University Medical Center for lectures and discussions of their specialties, a part of the expanded cancer teaching and research program of the Indiana University School of Medicine.

The series was initiated in January when Dr. Isadore Lampe of the University of Michigan participated in a two-day series of radiological conferences with the teaching and medical staffs of the I. U. School of Medicine and the University hospitals. The sessions were attended by a number of radiologists and physicians from over the state.

Dr. Robert E. Stowell, Department of Oncology, University of Kansas, is delivering two lectures at the Medical Center on February 16, discussing, "Histochemistry in Cancer Research" and "Histochemical Studies of Normal and Neoplastic Liver."

Third in the series of speakers will be Dr. Howard R. Bierman, University of California, widely known for his study of leukemic cells, who will visit the Indiana University Medical Center during the early part of May to discuss his research work.

The program, arranged by the School of Medicine and directed by Dr. E. A. Lawrence, cancer coordinator, has the support of the Indiana Cancer Society.

Renewal of a grant to Dr. Edward W. Shrigley of the Department of Microbiology, Indiana University School of Medicine, for continuation of his cancer research involving virus metabolism and virus induced tumors, using radio-active phosporus, has been announced by the Federal Security Agency.

For the second year the annual Postgraduate Course in Electrocardiography, presented February 15-16, by the staff of the Indiana University School of Medicine, has drawn more applications than could be accepted. The course this year again follows a one-day Heart Symposium for practicing physicians of the state which is presented with the cooperation of the Indiana Heart Foundation.

The Indiana University School of Medicine, with the cooperation of the Indiana State Medical Association, has expanded its postgraduate program by using telephone lines to carry lectures and discussions to county medical society meetings.

The series of Telephone Seminars has been increasingly popular, with the January program heard by members of 20 county societies. The February program will recognize the observence of National Heart Month, by presenting as speakers from their homes or offices Dr. Howard Sprague, Harvard University Medical School, president American Heart Association; Dr. Samuel A. Levine, also of Harvard University Medical School; and Dr. Arlie R. Barnes, of the Mayo Clinic, a past president of the American Heart Association.

A centralized dictation system, with special phone units located at physicians' work tables in each hospital ward connected with recording equipment at a central location, is being installed at the Indiana University Medical Center for greater efficiency in maintaining patient records and saving time for the medical staff. The installation is the first of its kind in a Medical Center, and follows considerable experimentation.

A grant of $3,100 has been renewed by the U. S. Public Health Service to Dr. William A. Summers of the Department of Microbiology, Indiana University School of Medicine, for continuation of his study of intracellular parasites causing a form of encephalitis.

The degree course in Medical Record Library Science offered by Indiana University and directed by Miss Gertrude Gunn, head of the medical records department at the I. U. Medical Center, has been given formal approval by the American Medical Association.

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A.M.A. WASHINGTON OFFICE NEWS

Army Physician Call-Ups to Total 1,733 by March. Physicians added to Army's rolls by men called up on mandatory orders and draft-eligible volunteers since the outbreak of the Korean War will reach 1,733 by mid-March. Army hopes its latest call for 980 company grade medical officers, will be filled by volunteers now classified "Priority I" under the doctor-draft-government-educated physicians with less than 90 days' active duty. A Selective Service spokesman said they are not to come through Selective Service, except as a last resort. Army hopes the men will volunteer for active duty with the reserves. The 980 physicians will go on active duty on two dates—February 5 and March 13. At the same time 850 dental officers, also classified "Priority I" are expected to report for duty.

Before this call for volunteers went out, Army had involuntarily called 208 reserves since July 1 and had requisitioned 545 draft-eligible physicians. All 545 are expected to be on active duty by February or March.

Admiral Pugh Nominated for Navy Surgeon General. Rear Admiral H. Lemont Pugh has been nominated by President Truman to succeed Admiral Clifford A. Swanson as Navy Surgeon General. Admiral Pugh received his medical degree from the University of Virginia, Department of Medicine, in 1923 and has served with the Navy since. For the last four years he has been Deputy and Assistant Chief of Navy's Bureau of Medicine and Surgery.

Defense Department Finances Red Cross Program: Physicians Needed. *Defense Department* has turned over $3,000,000 to finance *Red Cross blood collection program* and has earmarked an additional *$9,000,000* for the same purpose. Defense Department explained that while "the Red Cross has the basic organization and experience necessary to handle this task, the new and greatly expanded blood program of the Armed Forces required additional funds beyond the planned budgetary estimates of the Red Cross . . . None of these funds . . . are in payment for the blood itself, which is contributed by volunteer donors and no part of the funds will be used for the Red Cross civilian blood program. Red Cross accounting for all funds advanced by the Defense Department will be audited by finance officers of the Department of the Army." To meet its military and civil defense responsibilities, RC expects to require the full or part-time services of at least 50 physicians before July 1. If recruitment efforts fail, RC will have to ask the Armed Forces to assign physicians for supervising the 20 additional centers and for handling mobile units.

Rusk Committee to Guide Military in Call Up of Reserves. In a major policy change, Defense Department has asked *civilian groups* to guide it in determining the *total number* of medical and dental reserves who may be called to duty at any one time without unduly endangering the health of the civilian population. National Health Resources Advisory Committee of National Security Resources Board (*Dr. Howard A. Rusk*, chairman) and Armed Forces Medical Advisory Board (*Charles P. Cooper*, chairman) will share this responsibility. The three services periodically will submit their estimated requirements for review by Dr. Richard Meiling, Defense Medical Services director, who will call on the two committees for their views. *Final* decision will be made by the Secretary of Defense.

Defense Department also will get civilian advice in determining *which individual reserves* should be regarded as essential to a community, and therefore deferred. *State and local Selective Service Advisory Committees* will assume this responsibility, under direction of the Rusk group in its dual role as National Advisory Committee to Selective Service. The Defense Department says the services *"will be guided by the advice from the committee."* However, "when an officer declared essential as a civilian by the committee is urgently needed by one of the military departments, the final decision in each case will be rendered by the Secretary of Defense." (The new procedure does not apply to members of *organized reserve units.*)

New Council Formed to Handle Defense Department Medical Affairs. Defense Secretary Marshall has announced formation of a new *Armed Forces Medical Policy Council* to replace Defense Department's *Office of Medical Services* and assume its functions. Dr. Richard L. Meiling, director of the Office of Medical Services, is chairman of the new Council, whose other members are the three Surgeons General (Army, Navy and Air Force) and three civilian authorities in medical and health fields who have not yet been announced by Secretary Marshall.

Score of Major Health Bills Introduced Opening Day. On opening day of the eighty-second Congress, a score of bills important to the health services field were introduced in the *House. Almost all were considered in one form or another in the last Congress.* Included are: National compulsory health insurance, with a provision for federal aid to medical education; federal aid to local public health units; aid to nursing education; school health services; hospital construction and income tax deductions for voluntary health insurance payments.



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PHOSPHORUS	315 mg.	RIBOFLAVIN	0.7 mg.		

*Based on average reported values for milk.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

COMMITTEE ON PUBLICITY

November 3, 1950

Present: Homer G. Hamer, M.D.; D.S. Megenhardt, M.D.; and James A. Waggener, field secretary.

In the absence of Dr. J. O. Ritchey, Dr. Homer G. Hamer acted as chairman.

The following "Hints on Health" columns were approved:

Week of December 10, 1950—"Atomic Bombing"
Week of December 17, 1950—"Don't Rush"
Week of December 24, 1950—"Watch that Mole"
Week of December 31, 1950—"Color Blindness"

A letter from Doctor W. D. Britton, secretary of the Parke-Vermillion County Medical Society, was read, in which a request was made for a scientific speaker for their society meetings on November 15 and December 20, 1950. The committee requested Dr. Paul G. Iske to speak on "Cardiac Diagnosis without Laboratory Methods," at the meeting on November 15. Dr. Don J. Wolfram was requested to speak on "Modern Drug Therapy" at the December 20 meeting.

December 1, 1950

Present: J. O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; D. S. Megenhardt, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of January 7, 1951—"Healthiest Nation"
Week of January 14, 1951—"Crossed Eye"
Week of January 21, 1951—"Posture and Health"
Week of January 28, 1951—"Red Eye"

The Committee reviewed an advance copy of the story appearing in the *Indianapolis Sunday Star* Magazine section, Sunday, December 3, 1950, telling of the Telephone Post Graduate Seminars.

A folder received from the Erie Pennsylvania County Medical Society explaining their speakers bureau was reviewed, together with the comments of the chairman of their speakers bureau. It was the opinion of the committee that this type of program offered a good method for public relations and requested that the matter be referred to the Indianapolis Medical Society with the suggestions that they might be willing to try the plan as a test. If successful and considered worthwhile, it is the thinking that the plan might be recommended to each county society.

The secretary was instructed to write the Lake County Medical Society making inquiry as to their speakers bureau and how it is conducted.

The secretary was asked to obtain the costs on printing a pamphlet on "Atomic Bombing" for lay distribution through the offices of physicians.

It was reported that a survey was made of the newspapers in the state receiving the "Hints on Health" columns and that ten had requested their discontinuance. We were sending the column to 145 weekly papers; the list now totals 135.

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Surgical Anatomy & Clinical Surgery, Two Weeks, starting February 19, March 19, April 16.
Surgery of Colon & Rectum, One Week, starting March 5, April 9.
Basic Principles in General Surgery, Two Weeks, starting April 2.
Gallbladder Surgery, Ten Hours, starting April 23.
Fractures & Traumatic Surgery, Two Weeks, starting March 19.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 19, March 19.
Vaginal Approach to Pelvic Surgery, One Week, starting March 5, April 2.

OBSTETRICS—Intensive Course. Two Weeks, starting March 5, April 2.

MEDICINE—Intensive General Course, Two Weeks, starting April 23.
Gastro-enterology, Two Weeks, starting May 14.
Gastroscopy, Two Weeks, starting March 5.
Electrocardiography & Heart Disease, Two Weeks, starting March 19.

PEDIATRICS—Intensive Course, Two Weeks, starting April 2.
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LOCAL SOCIETY REPORTS

Boone County Medical Society members held a meeting at the Witham Memorial Hospital in Lebanon on January 2. The members participated in the postgraduate telephone seminar.

Clay County Medical Society members held a meeting at the Elks Home in Brazil on November 14. The speaker was Dr. John Palm, of Brazil, who spoke on "The Atom Bomb and Civilian Defense." Nine members were present.

Clinton County Medical Society members held a meeting at the Clinton County Hospital in Frankfort, on November 7. Thirteen members were present to hear Dr. Francis E. Carrel, of Frankfort present a paper on "Gerontology."

Another meeting was held at the Clinton County Hospital in Frankfort on December 5. Seventeen members were present, to participate in the telephone seminar and hold election of officers.

Dubois County Medical Society members held a meeting at the Huntingburg Country Club on December 14. Election of officers was held by the ten members present.



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Fountain-Warren County Medical Society members held a meeting at the Attica Hotel in Attica on December 14. Dr. Harlan English, of Danville, Illinois, spoke on "Office Urology." Twelve members were present.

Greene County Medical Society members met in Linton on December 14. The eighteen members who were present heard Dr. Sam Rotman, of Jasonville, speak on "Public Relations."

Hendricks County Medical Society members met at Merritt's, near Avon, on November 14. Nine members and guests were present. The guest speaker was Dr. R. M. Vandivier, of Indianapolis, who discussed "Chest Lesions Commonly Observed in General Practice."

Huntington County Medical Society members met at the Hotel LaFontaine in Huntington on November 7. Eighteen members were present to hear Dr. G. T. Bowers, of Fort Wayne, speak on "Gynecological Malignancies."

Another meeting was held on December 5, when the society participated in the postgraduate telephone seminar, and held election of officers. Twenty members attended this meeting.

Howard County Medical Society members met at the Hotel Francis, in Kokomo, on January 5. Dr. J. L. Doenges, of Anderson, spoke on "Principles and Objectives of AAPS." Forty-one members were present.

Jasper-Newton County Medical Society held a meeting at the Brook Hotel, in Brook, on November 8, when Dr. Edward T. Stahl, of LaFayette, addressed the members on the subject of "Low Back Pain."

Another meeting was held in Brook on December 13. The guest speaker was Dr. Nicholas Egnatz, of Hammond, who spoke on "Early Symptoms and Signs of Cancer."

Johnson County Medical Society members met at the Johnson County Memorial Hospital in Franklin on November 7. Fourteen members were present to hear the postgraduate telephone seminar.

Madison County Medical Society members held a meeting in Anderson on November 20. Fifty-two members were present to hear Dr. J. S. Battersby, of Indianapolis, speak on "Surgical Aspects of Lesions of the Esophagus."

The members held a meeting at the Delco Remy Company, in Anderson, on December 18. This was a business meeting, and fifty-four members were present.

Putnam County Medical Society members met at the Paulana Tea Room in Greencastle on December 9. The twelve members present elected officers for 1951.

Ripley County Medical Society members held a meeting at Versailles on December 28. Six members were present for election of officers.

Tippecanoe County Medical Society members met at the Lincoln Lodge, in Lafayette, on December 12. This was a business meeting, and election of officers was held. Fifty members were present. At this meeting Dr. J. C. Burkle completed twenty-seven years of service as secretary of the Tippecanoe County Society.

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT—DECEMBER, 1950

Disease	Dec. 1950	Nov. 1950	Oct. 1950	Dec. 1949	Dec. 1948
Brucellosis	6	5	2	2	0
Chickenpox	341	177	90	236	313
Diphtheria	7	4	15	33	45
Encephalitis	3	3	2	3	1
Erysipelas	2	2	0	3	0
Food Poisoning	1	26	6	2	0
Impetigo	2	0	12	5	1
Influenza	97	21	32	26	15
Infectious hepatitis	3	3	2	0	0
Measles	85	37	21	111	118
Meningitis,					
Influenzal	1	2	1	4	0
Meningococcal	1	2	0	0	0
Unclassified	8	3	3	4	2
Mumps	82	90	59	147	112
Paratyphoid	2	1	0	1	0
Pneumonia	74	62	42	45	53
Poliomyelitis,					
Paralytic	11	49	91	12	6
Non-Paralytic	1	16	31	4	0
Unspecified	23	36	31	13	3
Rabies in Animals	33	43	38	39	65
Rheumatic fever	1	1	0	0	3
Rubella	13	2	2	75	4
Scarlet fever	124	62	67	200	217
Septic sore throat	1	0	0	0	0
Tinea capitis	13	21	53	3	0
Tuberculosis,					
Pulmonary	139	162	142	111	158
Other forms	11	14	4	8	10
Tularemia	7	4	1	7	23
Typhoid fever	2	2	6	3	1
Whooping cough	180	151	153	87	46
Dysentery,					
Amebic	1	2	0	0	0
Shigella Flexner	1	0	0	0	0

Important messages are presented in the advertisements in our JOURNAL each month. New products are announced from time to time and information is presented regarding the use of products featured. Other types of ads emphasize services rendered and commodities offered that may be used in your practice, in your office, and in your home. Please tell the advertisers that you saw their ads in THE JOURNAL of the Indiana State Medical Association.



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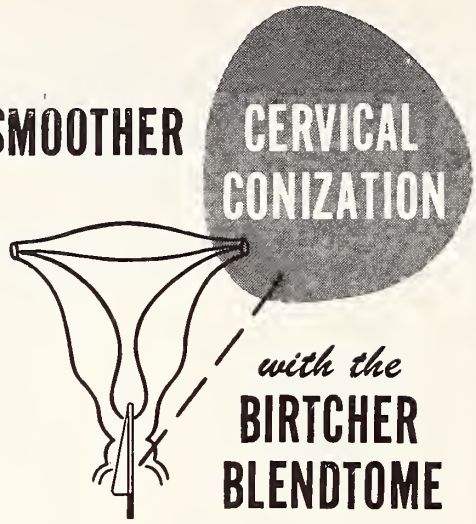
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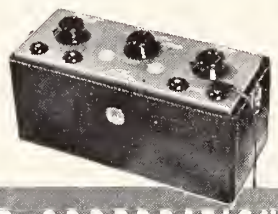
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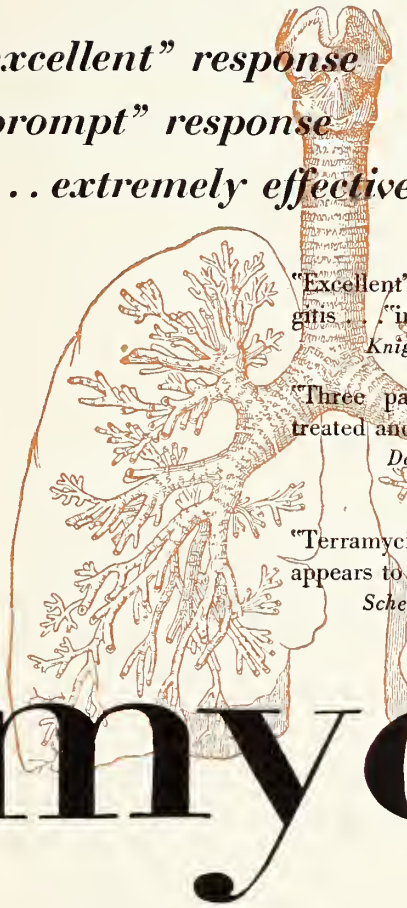
SEXUAL FEAR. By Edwin W. Hirsch, M.D., attending urologist at Englewood Hospital, Chicago. 307 pages. Price $3.00. Garden City Publishing Co., Inc., Garden City, New York, 1950.

There have been so many books on sex psychology that another one has to be good to attract serious attention. This book is undoubtedly intended to be a complement to the Kinsey report. The idea which the author wishes to convey, is, apparently, that sexual ignorance and fear are responsible for the high instance of sex neuroses and sex maladjustment. In the first six chapters of the book, the author takes up the history of sex behavior of various peoples throughout the centuries, beginning with the Babylonians. He described in detail the sex practices of the Babylonians, the Israelites, the Greeks, the Romans and other peoples, down to modern times. This historical account is interesting and presumably authentic. The author notes the high prevalence of venereal disease during the early periods, and the part it played in the downfall of many nations, especially Rome. Sex morals reached their lowest level at the time of the decadence of the Roman Empire. This account points out that the lowering of sex standards and other forms of depravity have been associated with the downfall of nations throughout history and that sexual vices and political corruption usually accompany each other. Although the author makes no mention of the influence of Christianity on sex relations and practices, it no doubt was a factor, since it had a profound influence on the stability of the home and family life.

One chapter of the book is devoted to the male climacteric. Such a clinical entity is not generally accepted. Many consider what is called the male climacteric as just one manifestation of senescence and is in no way comparable to the female menopause. The author also attempts to show that prostatism is usually due to prolonged sexual abstinence. All urologists do not subscribe to this theory. Much of the material in the book is informative, and it points out to the physician the importance of recognizing fear factors in frigidity, sexual impotence and sexual maladjustment. In the treatment of fear disorders, the author has coined a new term "psychomechanics" which merely describes a psychotherapeutic approach to disordered sexual function. In the treatment of these disorders, the author has more faith in hormones than is justified by the usual clinical observations. In the entire book the author pursues one clear line, that is, that sex fear is the predominant factor in all functional sex disorders and many other functional disorders not connected with sex.

The book concludes with an ample bibliography, and like many works on the subject, places sex in a greater segment of people's thoughts and lives than may be justified. Nevertheless, the physician should be mindful of the fact that sex ignorance and fear play an important part in many functional disorders. The book is worth reading for physicians, especially urologists, gynecologists and psychiatrists.

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Knight, V.: New York State J. Med. 50:2173 (Sept. 15) 1950.

"Three patients with beta-streptococcic pharyngitis were treated and made a prompt recovery."
Dowling, H. F.; Lepper, M. H.; Caldwell, E. R., and Spies, H.: Ann. New York Acad. Sc. 53:433 (Sept.) 1950.

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Schenck, H. P.: M. Clin. North America 34:1621 (Nov.) 1950.

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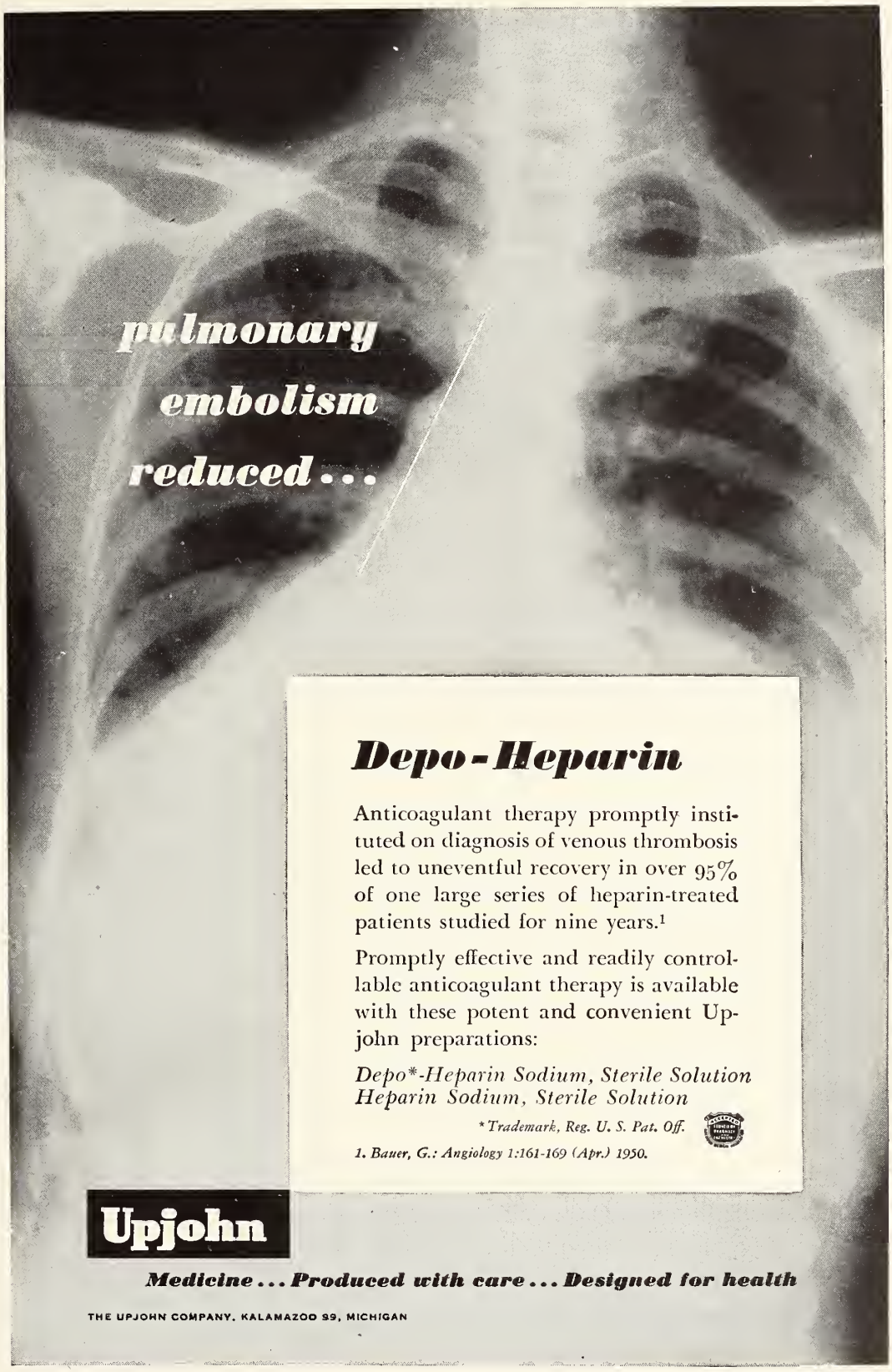
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1. Bauer, G.: Angiology 1:161-169 (Apr.) 1950.
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4.	Benet W. Thayer, M.D., North Vernon	D. W. Mathews, M.D., North Vernon	North Vernon, May 16, 1951
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6.	Will A. Thompson, M.D., Liberty	Robert W. Kuhn, M.D., Wilkinson	Liberty, May 10, 1951
7.	E. M. Pitkin, M.D., Martinsville	Ralph V. Everly, M.D., Indianapolis	Indianapolis, May, 1951
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11.	L. D. Holliday, M.D., Fairmount	C. R. Herd, M.D., Peru	Peru, May 16, 1951
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13.	Milo G. Meyer, M.D., Michigan City	O. E. Wilson, M.D., Elkhart	South Bend, November, 1951

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ARTHRITIS
ORTHOPEDIC ASPECTS*

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INDIANAPOLIS

GENERAL CONSIDERATIONS

ANY DISTURBANCE in the general region of a joint is frequently and sometimes loosely diagnosed "arthritis." This pathological process, when it actually exists, is not confined within a joint, but involves surrounding capsule, aponeurosis, tendons, bursae and muscles, as well.

With the exception of the traumatic form, arthritis is never a localized disease but rather the predominant manifestation of a systemic disorder. For example, in atrophic or rheumatoid arthritis, changes occur at other sites, such as wasting of distant muscles, together with loss of subcutaneous fat and peripheral vascular disturbance. Generally, there is weakness and fatigue with hypotension.

The term "arthritis" is not one to be used casually as a diagnosis. Its implications are extensive and the mental impact upon the patient may be profound.

Some types of the disease produce only mild inconvenience and are of no more significance than other changes of advancing age. Other types cause severe contractures with incapacitating disability.

The patient is likely to think only of the more serious forms, recalling vividly examples of horribly crippled arthritics. The diagnosis of any type of arthritis portends in his mind a tortured existence of invalidism.

* Presented at the annual session of the Indiana State Medical Association, at French Lick, September 26, 1950.

CLASSIFICATION

A working classification of the disease is presented here to clarify discussion.

1. Rheumatoid (atrophic);
2. Gout;
3. Specific Infections—gonorrhea, septic arthritis;
4. Degenerative (hypertrophic);
5. Traumatic (including occupational, postural, and static);
6. Miscellaneous—hemophilia, serum sickness arthritis, nonspecific infectious arthritis, et cetera.

ORTHOPEDIC MANAGEMENT

Virtually all cases early in development are seen either by the doctor in general practice or the internist. Once the diagnosis has been established in a given case the clinician should consider the overall picture and discuss with his patient, in so far as possible, the expected course of the disease.

Naturally, the patient's comfort is of immediate concern, yet if one does not keep in mind the possibility of severe joint contractures the position giving most comfort at the moment may result later in the most severe disability.

A flexed joint is the most comfortable regardless of the cause of pain. Knees, held in a flexed position when painful, soon become contracted. Uninvolved hip joints, necessarily flexed to an equal degree as the knees, also develop contractures and so the disability spreads. Contractures of the heel cords like-

wise may occur if the feet are not supported. Corrective measures then must be directed to six joint areas, while at the onset only two may have been diseased. In the most severe instances subluxation and complete dislocation of major weight-bearing joints have been seen after extended illness.

Management of these cases from an orthopedic viewpoint includes four objectives:

1) Prevention of deformities;
2) Correction of deformities;
3) Restoration of joint motion (arthroplasty); and,
4) Obliteration of joint motion (arthrodesis).

PREVENTION OF DEFORMITIES

The use of the term "Orthopedic Management" is not at all limited to the orthopedic surgeon. Prevention of deformities in particular is an important part of treatment which is most successfully instituted early in the disease by all physicians who treat arthritis. These men have the greatest opportunity to prevent contractures that may later require weeks of painstaking, laborious, and often discouraging effort to correct.

Preventive measures are simple, yet to be thoroughly effective they should be continued without interruption from the onset of the disease process.

Rheumatoid arthritis is the most notorious of all types to produce extensive disability with complex problems in preventing deformity. Numerous joints, frequently including those of the spine, are involved in rapid succession. Those deformities which make the patient an invalid if allowed to develop are:

a) the bent forward position resulting from involvement of cervical and dorsal spine;
b) a sharp restriction of respiratory excursion from costovertebral joint disease;
c) loss of the use of the hands; and,
d) multiple painful contractures in the lower extremities.

The patient should lie upon a firm bed regardless of spine involvement. Bed boards under a plain mattress will suffice. A soft mattress, merely by letting the buttocks sink into a hollow, contributes to hip flexion contracture.

Knee joints in the acute stage are swollen and painful. Skin traction to the leg with Buck's extension and five pounds of weight provides some immobilization and relief of pain. A small pillow beneath the knee, allowing not more than 10 degrees of flexion, is permissible.

Posterior plaster shells, extending from the transverse gluteal crease to include the foot, have an advantage in preventing heel-cord contracture. The extremity may be held in the plaster support with elastic bandage, but it should be removed several times daily for gentle active and passive motion at the hip, knee and ankle. One figuratively walks a tight rope here in keeping the joint at rest in an optimum position and, at the same time, avoiding ankylosis. Should ankylosis of the knee occur the best possible position has been maintained.

Rheumatoid changes appear early in the finger and wrist joints. A cock-up splint, removed frequently for motion, provides adequate support. This splint should extend onto the palm as far as the proximal transverse crease. Fingers are not splinted. Motion is encouraged in them because even though markedly deformed after years of disease they retain considerable function.

Types of arthritis other than rheumatoid have less tendency to cause widespread contractures. It is true that the tuberculous hip tends to flex and adduct. Here, one joint is involved. Complete rest of the joint is maintained in the best functional position until the active process has become sufficiently quiescent to allow surgical arthrodesis.

CORRECTION OF DEFORMITIES

Once the numerous joint contractures have developed in rheumatoid arthritis they are intensely resistant to correction. Periarticular soft tissues—muscles, tendons, and joint capsule—have become shortened and fixed.

Knee joints, contracted to a right angle, require weeks of wedged cast treatment combined frequently with posterior capsulotomy to get them straight. Hip joints, similarly contracted, are also brought down as the knees are straightened. The weight of the leg will do part of this but, in addition, soft tissue stripping about the hip may be required.

Wedged cast correction is also effective in wrist and ankle joint contractures.

ARTHROPLASTY

The hip, elbow, and occasionally the knee, are joints most frequently considered for this procedure. Weight bearing, poly- or monarticular disease, and the patient's occupation, are among several factors which influence the surgeon's decision.

Arthroplasty of the hip in rheumatoid disease has not been successful in our experience regardless of whether fascia or the vitallium cup is used. The extensive muscle wasting and periarticular fibrosis have prevented recovery of motion. Furthermore, associated knee involvement limits greatly the range of hip exercises so essential in the postoperative course.

This pessimistic attitude may change as hormone therapy advances. First of all, treatment early in rheumatoid arthritis may preclude the need for arthroplasty. And in the advanced cases pain may be reduced sufficiently in all joints to allow greater recovery of function in the operated one.

Arthroplasty of the hip in monarticular disease resulting from degenerative changes, nontuberculous infection and trauma is a different problem. Surrounding muscles, although atrophied from disuse, are capable of mobilizing the joint. Normal function in other joints of the extremity facilitates

recovery of hip motion. Reconstruction of the femoral head and acetabulum, using the vitallium cup as the interposing substance, has given many gratifying results.

Recent reports from France enthusiastically endorse the acrylic hip ball replacement of the femoral head in cases of degenerative and traumatic arthritis. The entire head of the femur is removed and the acetabulum reshaped if necessary. An acrylic prosthesis having the general contour of the femoral head is fixed upon the neck stump by a post running through the neck canal.

Hip reconstruction procedures usually necessitate removal of much of the joint capsule, which is thought to be the chief source of pain stimuli. Excision of the capsule may be largely responsible for relief of pain.

It is difficult to achieve a successful arthroplasty at the knee joint. Instability, persistent pain and diminishing motion commonly follow the operation. Involvement of the knee alone by a quiescent nontuberculous or traumatic process is the customary indication for arthroplasty. Multiple joint disease, affection of soft tissue, and bone atrophy in rheumatoid arthritis are contraindications to the operation.

Results of arthroplasty in an ankylosed elbow are most satisfactory of all. Lack of weight bearing and persistence of good function despite some instability are favorable factors.

OSTEOTOMY

Diagonal osteotomy of the upper femur has also improved function in the hip affected by degenerative or traumatic arthritis. Displacement of the distal fragment medially against the inferior rim of the acetabulum brings the extremity's weight-bearing line closer to the body's center of gravity and prevents adduction tendency at the joint. Stiffness of the knee may be prolonged because it must be immobilized several weeks to permit healing of the femur fragments above.

ARTHRODESIS

The question of performing surgery to eliminate or to increase motion in a given joint requires serious consideration. A laborer or farmer with monarticular hip or knee involvement will be back at work quicker and with less disability after arthrodesis than after arthroplasty.

We have performed arthrodesis of both knees in rheumatoid arthritis once the flexion contractures had been corrected. The patient had then either to stand straight or to lie flat because of stiff hips. Benefit is questionable.

Arthrodesis of a joint in the best functional position is still the goal in treating tuberculous disease. Most sinuses which once drained interminably to delay operation now respond to streptomycin. After drainage stops serial x-ray examinations show improvement in bone density and diminishing activity of infection. Arthrodesis may be done earlier and the less atrophic bone about the joint provides a better area for acceptance of the bone grafts.

NEURECTOMY

Section of the obturator nerve and the nerve to the quadratus femoris muscle may be done in an attempt to relieve pain when one or both hips show degenerative or traumatic arthritis. The operation is not a formidable one and it does not require long bed confinement. Although it produces remarkable relief of pain in some instances, results are not uniformly gratifying.

FEET

Small joints of the feet are involved early in rheumatoid arthritis. At first, these joints are swollen and painful. Later, hammer toes develop and the metatarsal heads become prominent in the sole. After the acute process has subsided resection of the second, third and fourth metatarsal heads makes weight bearing more comfortable.

A degenerative process localized to the first metatarsophalangeal joint is called hallux rigidus. Pain with limited dorsiflexion of the great toe interferes with proper walking. Resection of half the proximal phalanx of the toe provides a painless, well-functioning pseudarthrosis.

Gouty tophi about the foot may prevent comfortable shoe fitting. Surgical removal is indicated here the same as when the tophi appear elsewhere to impede function. Otherwise, treatment of the disease is medical.

CONCLUSIONS

Orthopedic management of arthritis should begin with measures to prevent deformities. It is to be hoped that these measures will prove much more effective and comfortable for the patient when combined with the newer methods of endocrine therapy.

Degenerative changes appear as difficult to forestall as advancing age. Nevertheless, patients with the disease may be made more comfortable by general and local conservative treatment, and occasionally by surgical measures.

OCULAR FUNDUS MANIFESTATIONS OF HYPERTENSION AND DIABETES*

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INDIANAPOLIS

THE STRUCTURES which we observe in the fundus are a highly differentiated peripheral sense organ, the retina, and the distal end of its nerve tract, the papilla. Vascular supply to the retina is provided by the central retinal vessels which branch out from the disk to the four quadrants. The visible arteries belong to the caliber of vessels which are classified as arterioles. Since the retina is a transparent structure some details of the choroid can be noted. The ophthalmoscope has provided us with an unusual opportunity for studying living tissue magnified to the same degree as a low-powered microscope by the media of the eye. The information obtained from these observations is often a great aid in the diagnosis and management of many diseases. This discussion will be limited to a consideration of the ophthalmoscopic findings in hypertension and diabetes.

HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE

Recent developments in the treatment of essential hypertension have focused attention on the importance of fundus changes in the diagnosis and proper management of this disease. Before describing these changes it should be emphasized that the only requirement for their appearance is an elevated blood pressure. Although the etiology of hypertension is varied, manifestations in the fundus are in no way characteristic of any type of hypertensive disease. Observations of the fundus provide important information which should be correlated with other clinical and laboratory data to evaluate accurately the disease as it affects the individual patient. Periodic fundus examinations should be routine on all patients who have an elevated blood pressure.

The vascular changes which appear in retinal vessels as a result of hypertension are vasospasm and arteriosclerosis. The histopathologic alterations found in the vessel wall are responsible for the ophthalmoscopic evidence of sclerosis. The pathology consists of a hyalin degeneration and thickening of the media. This produces changes in the light reflex and apparent size of the vessel. It has been shown that the amount of sclerosis observed in retinal vessels is indicative of the extent to which vessels in other organs are involved.[1] In evaluating the amount of sclerosis present it should be recognized that the pathologic changes are not uniformly distributed. For this reason there will be a difference in the degree of sclerosis in various vessels and variations in the course of the same vessel.

Early signs of sclerosis are widening of the light reflex and increased luster of the arterioles. Later the reflex becomes coppery in color and the veins are compressed at their intersection with arterioles. In the more advanced stages, the arterioles acquire a silver color and are narrowed, altering the A-V ratio. Finally the lumen may be almost completely obliterated and the arteriole appears as a fibrous cord.

Some degree of arteriolar constriction is present in most cases of essential hypertension. The constriction may be generalized or limited to segments of a vessel. If vasospasm persists sclerosis invariably develops. Vessels may show a mixed picture of sclerosis and spasm.

The retinal lesions which may develop in the course of a hypertensive disease are flame-shaped hemorrhages, cotton wool exudates, and less commonly a macular star. The appearance of these lesions is almost always associated with arteriolar spasm and the fundus picture is referred to as angiospastic retinopathy. In more severe cases retinal edema and papilledema may occur. The appearance of papilledema in a patient with essential hypertension is diagnostic of the malignant phase of the disease.

The diagnosis of early papilledema from any cause presents a problem to even the most experienced observer. The initial changes which occur are more easily understood by correlating them with the anatomic structure of the optic disk. The greatest crowding of retinal nerve fibers is found at the poles and nasal margin. These areas may appear blurred normally and will be the first to show the presence of edema. The temporal margin is usually distinct and when it becomes hazy there is further evidence of papilledema. A slight elevation in the nerve fibers will change the level of the vessels which are located in this layer. Any change in level alters the appearance of the light reflex and this can be observed as the vessel crosses the disk margin. Separation of the nerve fibers by edema tends to obliterate the physiologic cup. Another sign which may be helpful in determining the presence of papilledema is venous pulsation. In some eyes

* Presented at the annual convention of the Indiana State Medical Association, at French Lick, September 26, 1950.

there is normally no visible pulsation on the disk, so the absence of this finding does not aid in the diagnosis. When venous pulsation can be seen papilledema is probably not present. If it should develop any pulsation will disappear. As the process continues the disk becomes elevated by a measurable amount. Edema extends to the surrounding retina, making it difficult at times to observe the arterioles. Filling of the perivascular lymph spaces produces the ophthalmoscopic picture of sheathing or white lines on either side of a vessel. When there is marked elevation of the disk, hemorrhages and exudates will appear and the veins will be dilated and tortuous. Papilledema itself does not cause any impairment of vision. However, if it persists for six months or longer a secondary atrophy develops which may cause considerable loss of vision and even blindness.

The ophthalmoscopic findings which have been mentioned are not only observed in essential hypertension, but may be found in any disease which produces an elevated blood pressure. Other factors occasionally play a part in the appearance of a retinopathy. These include anemia and hypoproteinemia, both of which may occur in chronic nephritis. The degree of vascular change, presence of a retinopathy and the course it follows closely parallels the general condition of the patient. Often the appearance of retinal lesions will be the first manifestations that the disease has taken a more accelerated course. Where the condition is reversible, as in acute nephritis or toxemia of pregnancy, or the cause is removed, as in hypertension due to pheochromocytoma, recovery may take place. In these cases absorption of retinal hemorrhages and exudates makes the prognosis more favorable and the amount of vascular damage will depend on the severity and duration of hypertension. If permanent vascular disease develops it will be manifested by arteriolar sclerosis and persistent elevation of blood pressure.

DIABETES

There have been many excellent studies on fundus manifestations of diabetes mellitus. However, the problem of why these lesions occur, their prevention, and how to treat them remains unsolved. It is known that diabetes may affect all segments of the vascular system. The early and characteristic changes observed in the fundus are different from those observed in other organs, with the possible exception of the kidney. Histopathologic alterations in the glomerular capillaries, observed in Kimmelstiel-Wilson syndrome, may correspond to the capillary changes found in the retina. Damage to retinal capillaries is manifested by the appearance of punctate hemorrhages. This finding is considered by many as the earliest and basic lesion of a diabetic retinopathy, and it is not unusual for an ophthalmologist to make a diagnosis of diabetes on routine examination. Retinal hemorrhages are usually noted between the superior and inferior temporal vessels near the macula, and assume a round shape because of their location in the deeper layers where the cellular structure is loose. Capillary aneurysms may develop in these layers and it is difficult to differentiate them from punctate hemorrhages. In more advanced cases other types of hemorrhages may appear in any part of the fundus. Waxy exudates are generally observed in the macular region and they may be due to the extravasation of plasma from capillaries. This would be further evidence of capillary damage.

Capillary fragility studies on diabetics have indicated a weakening of the capillary wall. Increased capillary fragility is more marked in those patients who have a retinopathy. This observation led to the use of substances which have a tightening effect on capillaries. These agents are referred to as Vitamin P, and include rutin and hesperidin methyl chalcone (H.M.C.). Our experience with H.M.C.[2] did not substantiate the claim that this substance has any beneficial effect on diabetic retinal hemorrhages. It did improve capillary fragility but there was no corresponding change in the course or appearance of retinal hemorrhages.

Diabetic retinopathy may be observed in the presence of normal retinal vessels. This is often noted in young diabetics. Arteriolar sclerosis will appear if hypertension develops, or it may be a senile change. The occurrence of hypertension and diabetes in the same patient may produce a mixed vascular retinopathy.

Involvement of retinal veins is also characteristic of diabetes but does not occur frequently. Early there may be venous dilatation. In more advanced cases venous varicosities and sclerosis may develop. The appearance of these lesions is usually associated with large retinal hemorrhages and bleeding into the vitreous. Extravasation of blood into the vitreous is followed by the formation of bands of retinitis proliferans, a complication which has a disastrous effect on sight.

The fundus changes which occur in diabetes are further evidence of the vascular damage which will develop in almost every diabetic who lives long enough. All studies show that the duration of diabetes plays a dominant role in the development of these lesions. Older patients tend to develop a retinopathy earlier than younger diabetics. Severity of the disease and control do not appear to be important factors. Insulin has made it possible for large numbers of diabetics to live long lives, and the problem of how to protect the diabetic against vascular degeneration remains our challenge.

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INTRAVENOUS PITUITARY DRIP

C. O. McCormick, Sr., M.D.

INDIANAPOLIS

THE LONG-STANDING, dogmatic dictum, "Pituitrin is a criminal agent if administered before the birth of the child," has until recently held us in abeyance in developing the fullest utilization of this oxytocic. However, as with the mastering of strychnine, we have developed its administration and regulated its dosage to a degree that is now not only a safe, but a most important aid in handling such problems as induction of labor, inertia uteri, and abruptio placentae.

The disasters from the use of Pituitrin have not been due to the drug itself, but rather to our not having taught ourselves how properly to use it. During the past three or four years through the special technic, **intravenous drip**, its employment in handling certain obstetrical problems has become quite routine in some of our leading obstetrical clinics.

The administration by **intravenous drip** is more physiologic than the intramuscular and intranasal methods, and for that reason is safer and more efficient. Since **Pitocin**, perhaps not quite as efficacious as Pituitrin, reduces pituitary shock and eliminates the danger of blood pressure elevation in unrecognized preeclamptic patients, it is the better choice of the two preparations.

Technic of intravenous Pitocin drip for the induction of labor and treatment of inertia uteri:

(1) Mix 5.0 m. of Pitocin thoroughly with 500 cc. 5 percent glucose solution. (50 cc. of solution is equivalent to 0.5 m. of Pitocin.)

(2) For the first half hour administer with a pre-tested Murphy drip apparatus 0.25 m. of Pitocin—12 to 14 drops of the solution per minute —.8 cc. of solution.

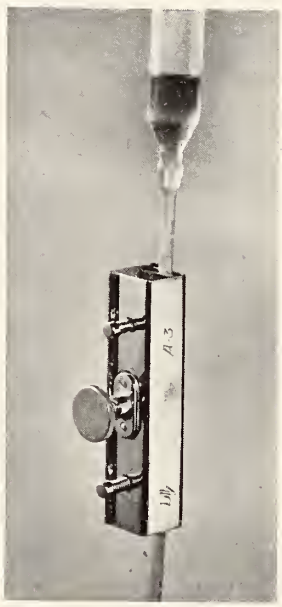
(3) After the first half hour, if .25 m. is not effective, increase to 0.5 m. of Pitocin over 30 minutes—25 to 30 drops of the solution—1.7 cc. of solution.

Precautions:

(1) Do not have the solution flowing when the needle is inserted—a dangerous amount of the Pitocin might be given before the flow is regulated. The number of drops should be built up from zero.

(2) The patient should never be left alone. The flow must be checked from time to time. Moreover, the clamp might slip. This mishap can be avoided by the use of the tunnel clamp herewith illustrated.* Because of its sturdiness and long (4 inch) application over the tube, slipping is eliminated. Also, it has the additional advantage of affording a more accurate control of the rate of flow.

(3) The uterine contractions must be observed constantly. If they exceed two minutes or if the fetal heart tones show abnormal variation, the clamp must be shut off immediately and remain shut until the disturbances are corrected. In the meantime, a normal salt solution by means of a Y-tube may be switched for the Pitocin solution.



These precautions must be observed unrelentingly. A pituitary oxytocic unscrupulously administered intravenously can be "dynamite."

The greatest use of **Pitocin drip** is in the treatment of postpartum hemorrhage. Eastman reports he has successfully substituted it for the intrauterine packing in treating uterine hemorrhage in their last 12,000 delivery cases. In dealing with this complication, the rate of flow may be increased from 60 to 70 drops per minute if indicated.

It appears Pitocin drip is destined to replace the intramuscular use of Pitocin and Pituitrin, as it can be employed advantageously, also, in incomplete and septic abortions, in some cases of hydatiform mole, and following the birth of the baby at Cesarean section.

Our personal experience with this technic has been limited largely to the induction of labor and the treatment of inertia uteri and postpartum hemorrhage. Although the results have been highly satisfactory, I must stress again the importance of observing carefully the precautions listed above, when Pitocin (or pituitary extract) is given before the birth of the baby. Although the extract may be administered with impunity when treating postpartum hemorrhage, it does carry more danger of Pituitrin shock than Pitocin, and the additional risk of elevating the blood pressure in preeclamptic patients.

621 Hume-Mansur Building.

* Manufactured by the Havard Appliance Company, Dover, Massachusetts.

A CRITICAL EVALUATION OF PARENTERAL PROTEIN THERAPY*

Don G. Bock, M.D.†

INDIANAPOLIS

INDICATION is present for parenteral protein administration whenever protein depletion occurs and it is impossible to maintain ingestion and absorption of protein by the oral route. Parenteral proteins are indicated in some cases of extensive burns, peritonitis, severe hemorrhage, intestinal obstruction, pneumonia, empyema, severe tissue trauma, draining wounds or sinuses, ascites, severe diarrheal conditions, regional enteritis, chronic ulcerative colitis, meningitis, and in some preoperative and postoperative cases.

It is well recognized that depletion of the albumin fraction of the plasma as well as a negative nitrogen balance begin immediately upon withdrawal of proteins from the diet.[1] Therefore, one must not rely upon stores of tissue protein to protect the plasma or to maintain a normal equilibrium between tissue and plasma proteins. Many patients today who are unable to ingest food or fluids are given intravenous glucose in water or saline with the assumption that the patient's nutritional requirements are being met. To be sure, there are present in the body stores of glucose and fat which can be utilized in time of need. Fat is itself dispensable and can be broken down and utilized as sugar. However, there are no true reserve stores of protein in the body and protein cannot be made from carbohydrate or fat. The only source of protein is exogenous. If glucose therapy is indicated, then surely protein therapy is indicated also.[2]

That carbohydrate is necessary for the synthesis of protein is recognized. Cannon[3] took protein depleted rats and gave them rations adequate in protein content, but at varying caloric levels. Synthesis proceeded in direct relation to caloric intake. With a caloric content below approximately 70 per cent of a given level recovery of weight was poor; above this level the addition of extra calories had but slight additive effect. Hence, there is need for enough calories for conversion of amino acids into tissue protein, but calories are superfluous above a certain level. Elman[2] states that 1,100 calories yield as much protein as 1,600. Probably the minimum daily intake should be 100 grams of protein and 100 grams of carbohydrate with a minimum of 1,300 calories, though 2,000 calories a day are probably indicated. In some instances a protein intake of 200 grams is needed to maintain a positive nitrogen balance. In extremely malnourished patients 200 to 300 grams of protein and up to 5,000 calories a day are indicated.[4]

For synthesis of proteins all essential amino acids must be present at the same time. Elman[5] in giving acid hydrolysate of casein with tryptophane, got good nitrogen retention in dogs, but got no retention when tryptophane was given six hours later. Cannon[6] has pointed out that in rats amino acid fractions even two hours apart give no nitrogen retention. Cox and Mueller[7] found the same thing with other essential amino acids as did Cannon. Melnick[8] has shown that an unequal rate of enzymatic digestion of some vegetable protein, such as soy beans, accompanied by an unequal rate of absorption of essential amino acids, explains why the vegetable proteins have generally poorer nutritive value than do animal proteins. The best source of protein, then, is animal protein. One should remember that, even if a patient eats his steak and eggs and drinks his milk, it does not mean that tissue protein will be made therefrom. Absorption from a diseased bowel may not be prompt, protein gets to the tissues at different times, is deaminized and lost, thus one gets calories, but not body-building proteins.[2]

Regarding plasma, Whipple and his associates[9] found that dogs could be maintained in nitrogenous equilibrium by the intravenous injection of plasma from other dogs as the sole source of protein. Howland and Hawkins[10] found that homologous plasma injected intravenously disappeared from the blood stream in 24 hours, yet there was no detectable rise in blood amino acid concentration or in urinary nitrogen. In phloridzinized animals the injections caused no rise in the excretion of sugar. Plasma proteins given orally to phloridzinized animals caused an increased excretion of urinary nitrogen and sugar. This suggests that large aggregates of amino acids (polypeptides) of the injected protein are utilized by the tissue cells. On the other hand, Elman[4] states that it is probable that plasma protein is broken down to amino acids before being utilized.

Holman, Mahoney and Whipple[11] gave large amounts of plasma intravenously to normal dogs over a period of several weeks. There was no significant escape of plasma into the urine. Apparently there is no renal threshold for plasma protein, though high plasma protein concentrations are attained (9.7 grams %).

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The Holman, Mahoney and Whipple group showed that during fasting periods plasma proteins are used up and total circulating proteins may decrease to one-half normal level, but plasma concentration changes little and significant change is in shrinkage of plasma volume. Other studies have been limited to changes in total protein and A/G ratios with no or only partial consideration of total plasma volume changes. Difficulties involved in determinations of total plasma volume, plus utilization of about eight different methods for determining plasma proteins, as well as variations in hydration (this very important), plus in some cases failure to report the A/G ratios, make evaluation of the literature on plasma protein changes in relation to nitrogen balance difficult.

Studies on dogs by Sachar, Horvitz and Elman[12] revealed that for every gram of plasma albumin lost as a result of insufficient intake of protein, approximately 30 grams of body protein is lost. Conversely, during replacement, approximately 30 grams of protein is required for the body tissues for each gram of plasma albumin regenerated. Hence Elman[1] observed that in chronic hypoalbuminemia due to malnutrition results were disappointing when giving plasma, there being scarcely any effect on the hypoproteinemia, only a transient diuresis, and little if any change in the edema resulted. The reason was that all the body proteins were down. The injected protein supplies other tissues and for every gram of plasma protein that remains in the blood 30 grams are removed for the rest of the body. For an example see Figure 1.

FIGURE 1

Example:

If the plasma albumin is down 1 gram %, this means a total plasma depletion of 32 grams. (Average 70 kilo man has 3200 cc. of plasma.)

Then, 32 (grams of plasma albumin to be replaced) x 30 (equals grams of tissue protein to be replaced for each gram of plasma albumin replaced) = 960 grams of protein needed.

If one pint of plasma contains 33 grams of protein, then 960 ÷ 33 = 30 pints of plasma, or the blood from 60 donors are needed to raise the plasma albumin 1 gram %.

Hence, we can see that administration of plasma for protein replacement in nutritional deficiency is impractical because of the cost and quantities of plasma required.

It is probable that administered amino acids are combined in the liver to form the various protein constituents.[1] In severe liver disease the liver may be unable to combine the amino acids efficiently.[13] Hence, in cases of severe liver disease parenteral plasma therapy is probably the most efficacious, since the plasma directly corrects the hypoalbuminemia. If a nutritional deficiency coexists, the administration of plasma is inadequate and too costly. It has been suggested[14] that in hypoproteinemia due to liver disease with ascites that autotransfusion with the patient's own ascitic fluid, providing that fluid is sterile and crystal clear, be attempted. However, ascitic fluid has only about one-fourth the protein content of plasma proteins and this method would seem to be of more theoretical than practical advantage. Fagin, Sayhun and Pagel,[15] in treating cirrhosis of the liver with parenteral amino acids, demonstrated an increase in protein content of the liver with a corresponding decrease in fat. Increase in plasma albumin was variable. Unfortunately, the amino acids are only of temporary value in treating cirrhosis of the liver.

It is well to point out that different proteins contain varying amounts of sugar forming amino acids. This was arrived at by calculation from the proportion of glucose (dextrose) to nitrogen in the urine—the so-called G:N (or D:N) ratio—in phloridzinized dogs fed exclusively upon protein during a period of starvation. Various reports of the G:N ratio vary from 2:1 to as high as 6:1. Minkowski's figure of 2.8:1 is most usually quoted (this would indicate the conversion of 45 per cent of protein to sugar).[10] In general we can say, then, that about one-half of the nitrogen in amino acids is utilized, the rest being deaminized and used as a source of calories. Actual minimum requirements for endogenous nitrogen metabolism are about four grams (equivalent to 26 grams of protein) per day,[1] though we usually consider about one gram of protein per kilogram of body weight a day as a practical minimum.

As to utilization of amino acids, in studies on nitrogen balance Elman, Sachar, Horvitz and Wolff[16] placed 13 dogs on a protein and fat-free diet for five weeks and were able to produce a positive nitrogen balance by the administration of intravenous amino acids.

Brunschwig and Corbin's[17] series of 41 patients subjected to a variety of major surgical procedures revealed a net loss of 81-175.8 grams of nitrogen in 36 cases over a ten day postoperative period. This corresponds to a loss of 506-1099 grams of protein over the ten day period.

Gardner and Trent[18] gave 362 intravenous infusions of amino acids to 30 patients over an average period of seven days. They arbitrarily gave 60 grams of amino acid daily to adults and 30 grams to children. Seventy grams of glucose were given with each 30 grams of amino acids. Nitrogen balance studies showed easy maintenance of nitrogen balance, with the exception of patients with fever, and in most patients immediately postoperatively. One case lost 25 grams of nitrogen in 24 hours. Hence, in patients with high nitrogen loss postoperatively upwards of 200-300 grams of amino acids may be needed to retain nitrogen balance.

Several studies have been made,[19,20,21,22,23] indicating the value of parenterally administered amino acids. It is to be emphasized that nitrogen requirements vary markedly in different cases. Up to 300 grams of amino acids can be given daily intravenously if needed. It is probable,

though, that the body can't assimilate more than 25 grams of amino acids per hour.[1] When given faster, nausea and vomiting tend to occur.

Madden, Woods, Shull, Remington and Whipple[24] demonstrated during administration of pure amino acids that high concentrations of glutamic acid, as are found in most amino acid hydrolysates, caused vomiting, and that the vomiting tendency diminished as glutamic acid concentrations were lowered. It is to be noted, however, that the glutamic acid concentrations in most amino acid hydrolysates are not higher than in meat or plasma.

Wissler, Steffee, Woolridge, Benditt and Cannon,[25] in giving six different protein hydrolysates to 60 rats, found marked variations in the quality of protein hydrolysates as measured by their capacity to induce tissue synthesis in the protein depleted rat. They emphasize that minimal standards of nutritional quality must be established for protein hydrolysate administration. To date no definite standards have been set.

SUMMARY

Some of the basic principles in parenteral protein therapy are as follows:

1. Adequate carbohydrate is necessary for maximum synthesis of protein.

2. All essential amino acids must be present at the same time in adequate proportions in order for protein synthesis to take place.

3. Nitrogenous equilibrium can be maintained by the administration of plasma or amino acids parenterally.

4. A/G ratios and plasma protein concentrations are not satisfactory means of determining the state of nutrition.

5. For every gram of plasma albumin lost 30 grams of body protein is lost.

6. Amino acids are combined in the liver. Plasma is utilized directly by the tissues.

7. Only about 50 per cent of amino acid nitrogen is retained, the rest being deaminized and used as a source of calories. Plasma nitrogen appears to be about 100 per cent retained.

Figure 2[26,27,28,29,30,31,32,33] compares the amino acids in various preparations.

Several points to be considered in Figure 2 are these:

FIGURE 2

Amino Acids Calculated to 16% Nitrogen	Daily Requirements	Animal Muscle	Bread	Whole Milk (Cow)	Casein	Plasma	Amigen (Mead Johnson)	Parenamine (Winthrop Stearns)	Aminosol (Abbott)	Travamin (Baxter)	Amino Acids Solution (Merck)
Tryptophane	0.9-1.2	1.2	1.3	1.6	1.8	1.7	1.3	1.0	0.9	1.4	1.8
Lysine	4.6-6.0	7.6	2.8	7.5	6.9	8.0	5.1	8.2	8 6	6.1	9.4
Threonine	3.2-3.6	5.3	2.8	4.6	3.9	6.3	2.9	2.9	6.4	6.0	1.9
Methionine	3.6-4.1	3.2	2–3	2.8	3.5	2.1	2.6	3.6	3.2	1.1	4.0
Cystine		1.1	2–3	1.2	0.36	2.1	0.3	0.42	2.7	1.2	0
Histidine	1.6-2.4	2.1	2.3	2.5	2.5	2.6	1.9	1.6	2.9	1.9	4.2
Leucine	5.4-12.6	12.1	11.2		12.1	18	9.1	11.6	7.8	7.3	16.5
Iscleucine	3 0-3.7	3.4	2.8		6.5	3	4 9	6.1	4 8	3.9	8.0
Valine	3.2-4.2	3.4	3.1		7.0	6	5.3	7.3	4.9	6.2	7.0
Phenylalanine	4.2-4.7	4.5	5.1	5.7	5.2	5.4	3.9	3.6	3.2	3.3	5.3
Arginine	1.2-4.7	7.2	3.5	4.3	4.1	5.8	3.2	3.9	6.8	4.9	2.5
Tyrosine	3.9	3.1	4.4	5.3	6.4	5.4	4.6	5.4	2.8	?	0
Glutamic Acid		15			22.8	18-25	17.1	21.6	13.7	10.34	1.5

Source				Human	Hydrolized Casein	Hydrolyzed Casein	Fibrin Hydro-lysate	Digest of Bovine Plasma Prot.	Hydrolyzed Casein
% Hydrolysis to Amino Acids				4.4 mg. %	75%	78%	50%	50%	100%
Total Protein Gm. %	10-20	13	3.5	6.6	3.75	15.0 6.0	5.0	3.75	8.3
Total Nitrogen Gm. %	2.4		0.56	1.06	0.60	2.05 0.82	0.65-0.70	0.60	1.3
NaCl/litre or kilo	9.26	5.82	1.75	5.6-6.8	2	Na 0.50 0.16	Na 0.1-0.2	3	Na 0.5
pH				7.4	6.5	4.0-4.1	5.0-5.5	6.3	5-7
% Reactions				2.96 in 10,000 cases	0.8% in 3,000 cases	?	?	0.72% in 2,003 cases	?

No responsibility is assumed for accuracy of data concerning the different products.

FIGURE 3

Amount of Preparations Required to Give 100 Gm. of Protein Daily

Preparation	How Available	Amount Required	Total Calories	Cost/Day
Amigen	1000cc. 5% Amigen in 5% glucose.	2.6 liters	923	$ 9.75
Parenamine	1) 15% Sol. Give 100cc. per 500cc. 5% glucose, or 300cc. per 1000cc. 5% glucose.	1) 660cc. 15% Sol. in 2000cc. 5% glucose.	1) 800	$ 14.30
	2) 100cc. 6% Parenamine in 5% glucose.	2) 1.66 liters	2) 732	$ 6.23
Travamin	1000cc. 5% in 5% glucose.	2.6 liters	923	$ 9.75
Aminosol	1000cc. 5% in 5% glucose.	2.0 liters	800	$ 6.80
Amino Acids Sol.	Not available.			
Plasma	pints	1.5 liters	412	$198.00
Meat	pound	1.1 lbs.	1000	$ 1.10
Milk	quart	2.9 quarts (14 glasses)	Fresh 2000 Skim 1044	$ 0.52
Bread	pound	1.5 lbs. (26 slices)	2080	$ 0.21

1. Comparisons of amino acid concentrations of various materials are given. It can be seen that considerable variations occur. These variations are difficult to evaluate, since no definite standards for amino acid concentration requirements have as yet been established.

2. Comparison of total protein and nitrogen levels are as indicated. Considerable variations are noted here.

3. Sodium chloride is present in considerable quantities in Amigen, Travamin and plasma, but is noted to be negligible in Parenamine and Aminosol.

4. Variations in the degree of hydrolysis of the various hydrolysates of amino acids are shown.

5. pH's are given. It has been suggested that the more nearly normal the pH, the less likelihood of trauma to the intima of the vein.[34]

6. The levels of glutamic acid, said to cause nausea at high levels, are given. Note, however, that animal muscle, casein and plasma levels are higher than in some of the hydrolysates.

7. Reaction rates are given. No serious reactions following hydrolysate administration have been reported in contrast to plasma in which homologous serum jaundice is a possible sequela.[35] However, commercial plasma which has been irradiated with ultraviolet appears to be free of the hepatitis producing virus.[36]

Figure 3[37] shows the comparative costs of the different parenteral protein preparations.

CONCLUSIONS

1. A review of some of the basic principles in parenteral protein administration is given.

2. That parenteral amino acids offer cheaper and more practical administration than plasma for nutritional deficiencies is shown. It must be appreciated, however, that the administration of parenteral amino acids in order to correct a protein deficiency, while at the same time supplying daily requirements (say 100 grams a day for deficiency plus 100 grams for daily requirements), entails giving each day several liters of the various amino acid preparations. This is quite expensive and creates a formidable task to accomplish mechanically.

3. Plasma is indicated when loss of plasma proteins is not associated with a coexistent nutritional deficiency.

4. The need is stressed for establishment of minimum amino acid requirements in man and for a minimum standard for protein hydrolysate preparations.

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Case Report

HERPES GESTATIONIS

Case Report

H. H. Rodin, M.D. and Robert Bryan, M.D.

SOUTH BEND

HERPES GESTATIONIS is a rare cutaneous complication of pregnancy. This case is presented because of its rarity and because no report has been made of treatment with newer antibiotics.

Ormsby and Montgomery[1] state that herpes gestationis is a variety of dermatitis herpetiformis. The etiology is unknown; however, pregnancy is generally accepted as its exciting cause. The disease may occur at any time in pregnancy, but rarely before the fourth month. Its onset is marked by an intense pruritis, followed by erythematous patches and later with herpetiform and bullous lesions. The symptoms may fluctuate in intensity but usually persist to delivery, with an occasional exacerbation following termination of pregnancy.

The outlook for the mother is usually good, although the condition may increase in severity with succeeding pregnancies.

The prognosis for the infant is poor. Fetal abnormality, stillbirth and death of apparently normal newborns are common.

Therapy has been empiric, based on the many theories of causation, and, with the possible exception of sulfapyridine, is usually ineffective.

CASE REPORT

Mrs. P. B., a 31-year-old gravida IV, was first seen March 25, 1950. Her last menstrual period was October 10, 1949. Two previous pregnancies were essentially normal. The third ended in abortion at six months, from unknown cause. Her past history revealed an appendectomy, thyroidectomy and removal of an ovarian cyst. Her estimated confinement date was July 17, 1950.

She stated that for one month prior to the first visit she had intense generalized burning and itching of the skin. She was referred for dermatological consultation.

Physical examination May 9, 1950, was essentially negative except for a generalized skin eruption. The tendency toward grouping which is characteristic of dermatitis herpetiformis was ab-

Figure 1



Figure 2



sent. The eruption consisted of urticarial plaques, vesicles and crops of bullae, creating a rather polymorphic picture. The lesions tended to spread centrifugally, producing circinate or gyrate patches with elevated edges and scaly, hyperpigmented centers. No mucous membrane lesions were present. In spite of the intense pruritis and burning few excoriations were noted.

A diagnosis of herpes gestationis was made and treatment was instituted with sulfapyridine (0.5 gm. q. i. d.), permanganate baths and an antipruritic lotion. This therapy failed to improve the eruption or general condition of the patient. She was then placed on aureomycin, 250 mgm. 4 times daily, which not only failed to give relief but had to be discontinued on the fourth day because of diarrhea. Chloramphenicol (chloromycetin), 250 mgm. q. i. d. for one week, likewise failed to alleviate the symptoms.

The disease failing to improve, and the patient's general and mental condition becoming rapidly worse, she was admitted to Memorial Hospital on June 7, 1950. Termination of her pregnancy was strongly considered. After obstetrical consultation medical induction was attempted but failed, and the membranes were ruptured. She subsequently delivered a normal appearing, 2 lb. 6 oz. female. The baby expired 50 hours later. The infant showed no evidence of a skin eruption.

Laboratory data: Urinalysis was essentially negative. Blood count revealed Hb. 77% or 11.5 gm., R.B.C. 3,900., W.B.C. 15,500. Polys. 54%, Lymph. 17% and Eosin. 26%. A second blood count (2 weeks postpartum) revealed Hb. 78% or 11.7 gm., R.B.C., 4,350, W.B.C., 23,000, Poly. 68%, Lymph. 12%, Eosin. 20%.

Two weeks postpartum only slight improvement was noted in the old lesions, and new crops of vesicles continued to develop almost daily. Sulfapyridine, 0.5 gm. q. i. d., again failed to produce relief. She was then placed on liquor potassii arsenitis (Fowler's solution) with dramatic result. Within one week the entire skin was almost clear except for an occasional vesicle and rather extensive postinflammatory hyperpigmentation.

The patient was last observed in September 1950, when she stated that she had suffered several mild relapses during the past month. In each instance a course of treatment with Fowler's solution controlled the disease in a few days.

SUMMARY

1. A case of herpes gestationis is reported which failed to respond to sulfapyridine, aureomycin and Chloramphenicol (chloromycetin) during pregnancy.

2. The disease responded dramatically, two weeks postpartum, to liquor potassii arsenitis (Fowler's solution).

3. The prognosis for the mother was good; for the infant, poor, the child expiring 50 hours after birth.

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SYMPOSIUM ON MALIGNANT DISEASE

The Fourth Annual Symposium on Malignant Disease will be presented at the Indiana University School of Medicine on April 3 and 4. The symposium is presented by the Indiana University Schools of Medicine and Dentistry, with the support of the Indiana Cancer Society. Speakers already scheduled include: Dr. Guy Aud, of Louisville; Brigadier General Wilford Hall, of the Army Air Force Medical Corps; Dr. Bernard G. Sarnat, Chicago; Dr. John J. Bittner, Minneapolis; Dr. Warren H. Cole, Chicago. No advance registration is required, and there is no registration fee. The program is open to all Indiana physicians and dentists.

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AMERICAN MEDICAL EDUCATION FOUNDATION

"DETERMINED to prove that 'actions speak louder than words' the House of Delegates of the A.M.A. overwhelmingly approved the recommendation of the Board of Trustees for the appropriation of one-half million dollars of association funds for aid to needy medical schools. On the following day it was announced that some $20,000 additional in gifts had been pledged to the fund, much of it from physicians attending the meeting."

Since the above announcement was made the American Medical Education Foundation has been created by the A.M.A. to administer the fund which was so generously inaugurated at the Cleveland Clinical Session. The Foundation will receive contributions from physicians and friends of medicine and will distribute the proceeds to all approved medical schools in the United States.

During recent years the medical schools of this country have been struggling with a three-fold problem; rapidly increasing costs, decreasing income, and the need for educating more and better doctors. Privately endowed schools have been especially affected. Government supported schools have shared in the dilemma because appropriations have not kept pace with the increased costs and responsibilities.

Plans to subsidize medical education with Federal funds have not been favored by physicians, because of the danger of centralized control which would be inherent in such a system of relief.

A significant statement was made in the announcement of the Foundation. "The funds will be given for unrestricted use—each school being entirely free to determine how best it can use its share to improve the basic training of its medical students."

The Board of Directors of the Foundation is now appealing to all physicians, with the knowledge that the medical profession cannot shoulder the entire burden by itself, but with the hope that if the profession leads the way, outside sources will lend aid.

Each physician is being asked to consider an annual contribution of $100. While many of the individual gifts already made have exceeded this amount, it is, of course, realized that some will find this outlay to be a burden. Smaller contributions are being encouraged; each dollar in the fund will create immeasurable good. The principle on which the Foundation is based is that all doctors should be privileged to share in this great enter-

prise. It is one which is close to the hearts of us all.

This is one of the most forward-looking and constructive programs which American medicine has undertaken. Its success depends on the cooperation of individual doctors. It will preserve the freedom of medical education. It will mean the improvement and extension of medical care for many years to come. It is a solid blow struck in the fight against government domination of medicine and medical education.

". . . AND THE ART IS LONG"

ON JANUARY 11, 1951, at Farmersburg, Indiana, a community tribute was paid to Dr. Jacob T. Oliphant and to his wife. The ceremony was well attended and fittingly conducted and would have been a credit to any city in the state. Farmersburg is a small place, in the census, but it is large in heart and in the capability of its citizens to express themselves. In his reply to the encomiums and gifts heaped upon him, Doctor Oliphant again demonstrated the stuff of which a good general practitioner,—and especially a country doctor—is made. Forty-five years of practice and of living with his patients as friends and neighbors have given him an insight into the art of medicine which his city cousins can scarcely hope to attain, and the entire profession of the state of Indiana can take just pride in Farmersburg's tribute.

"HEALTH PROGRESS IN THE UNITED STATES"*

A SURVEY of recent trends in longevity is presented in pamphlet form under the above title by American Enterprise Association, Inc. This presentation is one of a long series of publications devoted to current economic and social questions.

The analysis of longevity and mortality statistics brings to light many evidences of first-rate medical care in the United States; especially during the past decade. Chief among these is the well-known fact that the average length of life has increased by more than 18 years during a period of less than fifty years.

Much of this gain has been produced by an almost complete elimination of many infectious diseases as a cause of death. The lowering of infant mortality from all causes has contributed to this record. Although the average length of life has been increased mostly by the better mortality experience in infancy and early adult life, there have been gains in expectation of life at older ages. These gains for oldsters, although small, have been consistent.

Improvement in longevity, when examined by regions or groups, is found to have occurred at a greater rate in the instances in which it was poorest a half century ago. The south and southwest states, the nonwhite population and the members of wage-earning families formerly had records below the average. The rate of improvement has been above the average. In the case of the members of wage-earning families the statistics are now practically identical with the general population.

Mortality rates for classes of the people generally considered at the lower end of the social-economic scale have shown the same tendency to improve at a greater rate, and are now considered to be close to the rates for the population as a whole.

While the author of the above analysis does not go into the basic reasons for the amazing health records of the United States, it is apparent that many factors have contributed to it. One of these factors is medical care.

This study would indicate that the benefits of improved medical care have been accrued to all the people, regardless of occupation, race, social standing or economic status. In spite of the socializers' propaganda to the contrary, the American system of free medicine is now and for many years has been effective in promoting the health and well-being of our citizens in all walks of life.

* American Enterprise Assn., Inc., Publishers, 4 East 41st Street, New York 17.

NURSING "EDUCATION"

INDIANA has a number of hospital training schools for nurses. These schools were formerly closely coordinated with and subsidiary to the medical staff, but a change has gradually come over the field of nursing education so that it now is on a distinctly bureaucratic basis. The president of the Surgical Association of Louisiana, Dr. Isidore Cohn, delivered an address on November 11, 1950, in which he said, in part (*New Orleans Medical and Surgical Journal*, January, 1951):

> The tendency is to try to drive out of existence the hospital training school for nurses and to substitute *pseudo-doctors, social workers,* and *psychologists* for the time-honored humane cooperative service rendered by the registered nurse. The highly educated personnel envisioned by the nursing educators would deprive the public of the well-trained bedside nurse and substitute nurses aids and ward helpers.

If you do not believe this, read the following (also from Doctor Cohn's address) carefully:

> The present trend in nursing education is to develop nursing education schools within universities. It is the planned purpose of this group: "For the university school to enter into relations with other institutions exclusively to obtain necessary clinical laboratories and not to help provide nursing service for patients." One of the supervisors of a School of Nursing with a university status stated: "In Nursing Education the student is the center of

the program, whereas hospital nursing service revolves about the care of the patient. The School of Nursing is no part of our hospital organization."

These nursing educators would have the hospital training schools which have apprenticeship type of training "relinquish their schools to auspices whose exclusive function is education."

The nurse, under this scheme, will receive a chromium-plated education, much of which will be subject matter formerly considered part of post graduate training for nurses desirous of becoming supervisors, surgical nurses, obstetrical specialists, and the like, all of which looks good in catalogues and may enable student nurses to make high grades on state board examinations, but—where and when will these once eager girls learn the *art* of nursing, real bedside nursing? We use the term "once eager" advisedly, because by the time the girl has been exposed for three years to the present system, her once warm zeal to be a nurse has been regimented along "educational" lines and she has congealed into a little bureaucrat,—smart, perhaps, and keen on reports, but not always tactful, not always sympathetic, not always skillful in handling patients. This thing has been carried so far that older, experienced, and *wise* nurses in one hospital we know of, seldom if ever offer advice or help as a preceptor to student nurses because such teaching is distinctly frowned upon by the educational department.

We cannot help feeling that the apprentice method is "tried and true" and it is still advocated by some who should know,—as witness further extracts from Doctor Cohn's address:

Myron Anderson very frankly stated: "It is not necessary to destroy the present system or to make the registered nurse a displaced person in order to improve nursing education." We thoroughly agree with his conclusion that "Bedside nursing is a skill which must be learned and taught largely by the apprentice method."

Miss Margaret Conrad, the Director of Nursing at Columbia University Medical Center, has forcefully reminded nursing educators that "the fundamental principles of nursing and health become effective at the bedside, the clinic, and in the hospital. No amount of pressure should shake one's firm conviction on this point."

Sister Henrietta, the Director of the School of Nursing at Charity Hospital in 1948, stated:

"The nursing department which we are going to organize will be built to serve the patient. * * * The statement is heard frequently that better education of students will result in better care of patients. But does it?"

This is a subject in which doctors should be thoroughly, belligerently and unflinchingly interested. Sentiments similar to those of the doctor from Louisiana have been heard at times in the state of Indiana, and on account of similar provocation. Nurses themselves are not blind to the tendencies mentioned above, and even patients are beginning to "catch on,"—some ask to have "older nurses" secured to attend them.

The pendulum has already swung far in its present direction. Is it too much to hope for a force of gravity (or should we say *sanity?*) to check and redirect it?

SHORTAGE OF MEDICAL TECHNOLOGISTS

WHILE everyone is discussing and attempting to alleviate the shortage of doctors and nurses, it might be well to include another group of medical workers in the discussion. Medical technologists are in short supply, and even the limited calls occasioned by defense activities to date have reduced the numbers of this highly trained group to a minimum.

The increase in number and enlargement of stations for the procurement of blood for the blood derivatives program will create further demands for well-instructed technicians. In the event of atomic warfare there will be even greater need for such personnel.

Laboratory training for technologists must be conducted in a hospital which is large enough to afford the proper volume of work for such education. For this reason, medical technologists are urging all hospitals, whose facilities meet the technician-training requirements of the A.M.A., to establish schools of medical technology, if they are not already doing so.

College or university courses which are required as a prerequisite to laboratory study are adequately provided for. It is the hospital laboratories which are the limiting factor, and which should be utilized to the maximum extent possible.

The Council on Medical Education and Hospitals of the A.M.A. has set standards for training in medical technology, in order that graduates may be examined and certified. Information may be obtained from the Council by any hospital contemplating such a program.

The education of laboratory aides should also be encouraged. The demand for personnel who are qualified to perform the simpler laboratory procedures is sufficient to warrant encouraging this type of training. Laboratory aides bear the same relation to medical technologists as nurse aides do to registered nurses. The recommended course of study is one year in length, after at least a high school education.

Hospitals which are conducting courses for medical technologists may not train laboratory aides. This makes it possible for the smaller laboratories, not able to qualify for technologists courses, to engage in the overall program by training laboratory aides.

President's Page

THE WISDOM AND THE COURAGE

ONE OF OUR most important meetings held during the year is the Annual Conference of County Medical Society Officers. The twenty-sixth such meeting was held in Indianapolis on Sunday, January 28. These meetings have always attracted wide interest and have been well attended. For many years they have been under the chairmanship of Dr. A. M. Mitchell and the meeting has come to be known as "Mitchell's Secretaries Conference." He deserves great credit for developing the meeting to its present high standard. The chairman of this meeting for each succeeding year is elected by the assembly. Upon learning of Doctor Mitchell's recent illness the group honored him by electing him Chairman Emeritus, which was indeed a very popular honor for him.

This state-wide meeting of the officers of each of the county societies is a reminder to all of us that the affairs of medicine are simply the affairs of the individual practitioner. It is true that certain programs and plans need to be initiated and carried out on a state level but the distribution of medical care, the quality of medical service rendered and the regard with which the public holds us, all depend upon what the individual doctor thinks and does. So, this annual meeting of the county representatives of the practitioners has the "grass roots" background so important in our affairs.

There is no matter more important to us now, with the one exception of our responsibilities in military and civil defense, than that of furnishing good medical service, when it is needed and at a price the patient can afford. This is the essence of public relations. The American Medical Association can spend 1.1 millions dollars and our own State Coordinating Committee $65,000, all in an effort to make people think well of us, but if here and there we have a member who, because of human frailties, overcharges his patients or fails to render a quality of care and service which fair-minded people expect, these efforts on a national and state level won't do much good. The essence of public relations does not reside at A.M.A. headquarters or at our state headquarters, but it resides in the office of the doctor who might be reading this. The matter of our public relations is not a complicated one. It is indeed a simple one. If every patient, upon leaving his doctor, believed that he had been treated fairly and honestly we would not have any problem in public relations. It is as simple as that. Nothing could be more "grass roots" in nature.

Let it be clearly said that by far the great majority of physicians in Indiana live by the Golden Rule. But at the same time let us be as honest and state that there is a small number of doctors, the same as there is a small number of lawyers, of bankers, of farmers, in fact of all human beings, who by their unfortunate avarice and inhumanity, are constantly making enemies for themselves and, unhappily, for the whole medical profession. Their misdoings have been spotlighted by recent attacks upon us by socialist planners and the criticism has been contagious. This is the crux of our trouble. And a serious trouble it is. There is nothing which is more "grass roots" than the handling of it. May I point out to the officers of the eighty-two county medical societies in Indiana that the membership of our state organization and of our national organization is determined entirely by the action of the respective county societies? Our whole structure is based upon the county society. Any member who conducts himself so as to reflect upon his fellow physicians and bring discredit to his profession may and should be brought before his county society for a review of his conduct. It is the profoundly important duty of each county society to recognize such deviations and to correct them. If we do not have the wisdom and the courage to do this within our own family, it is my earnest belief that some other agency will handle this problem—and in a way which would bring unhappiness to us all. Let us have this wisdom and this courage NOW.

Alfred Ellison

Medical Panorama by the Associate Editor

"Polio" in Wythe County, Va.

In *Virginia Medical Monthly* for January 1951, the state health commissioner, L. J. Roper, M.D., reports some interesting statistics from a polio epidemic and a clever comparison with research data obtained by another worker:

In a report to the recent meeting of the American Public Health Association in St. Louis, Dr. T. B. Turner, of the Johns Hopkins School of Hygiene and Public Health, pointed out that children and adults develop antibodies because of one or more contacts with poliomyelitis virus in their childhood. Only rarely do these contacts result in recognizable clinical disease.

In a survey of 970 persons of varying ages in Baltimore, blood specimens were tested to determine the level of infection in different age groups. The test for antibodies was against the Lansing Virus, one of the three known types causing human poliomyelitis.

On those tested Dr. Turner reported the following reactions:

Under 3 months	72% had protective antibodies
3 months—1 year	10%
1-4 years	50%
5-9 years	72%
10-14 years	84%
15 years and over	90%

In a review of 185 reported cases of poliomyelitis from Wythe County in 1950 the age grouping of these cases is shown in the following table:

	No. of cases		Possibly Protected in General Population
Under 1 year	8	4.3%	
1-4 years	62	33.5%	67%
5-9 years	56	30.3%	70%
10-14 years	28	15.1%	85%
15 years and over	31	16.8%	83%
	185	100.0%	

With the high attack rate in Wythe County and the distribution of reported cases, it may be assumed that the virus was widespread over the county and that all age groups, with the possible exception of young infants, had the opportunity to become infected. If we assume that in the main those who did not come down with poliomyelitis had protective antibodies because of infection at some previous period, then the similarity in the Baltimore series and the Wythe County series as regards protection, is interesting and possibly significant.

We are aware of, and have attempted to avoid, an all too common tendency in the use of statistics. In a recent debate between representatives of a British and an American Institution, the Britisher accused his opponent of using statistics as a drunken man uses a lamp post; for support, rather than illumination.

We hope Doctor Roper will be glad to know that his arithmetic (really a simple subtraction of a part from the whole) appeals to us as both illuminating and supportive. Whenever medical practice, or clinical findings and theoretical statistics agree, we consider it a noteworthy matter.

Histoplasmosis in Iowa

A recent article in *The Journal of the Iowa State Medical Society* (January 1951) by R. S. Derifield, M.D., and R. L. Cole, M.D., concerns a study on skin sensitization to histoplasmin made on patients chosen "at random from the medical wards" with the exception of those with active tuberculosis, at the Veterans Administration Hospital, Des Moines. All subjects were skin-tested, intradermally, with histoplasmin and with tuberculin (PPD) at the same time.

The age group 20 to 29 showed twice as many reactors to histoplasmin as to tuberculin, but from 30-39 on up in age, the proportion was approximately the same, although the maximum for histoplasmin lasted through the fifth, sixth and seventh decades, while that for tuberculin was reached in the fifth decade and fell slowly thereafter.

As the authors state:

Because extensive selection as to sex and age exists in veteran patients, it is hazardous to attempt to draw too broad conclusions from data derived from this source.

Still, since histoplasmosis has been found in Indiana in significant numbers of cases, any well-controlled study of it is of interest to us.

In patients from the southern half of Iowa, 68 percent were found sensitive to histoplasmin, "whereas in the northern half 38 percent reacted. A reaction to tuberculin was present in 43 percent in southern Iowa, and 48 percent in northern Iowa." The authors' concluding paragraph on theory of source and transmission of infection should be provocative to some Hoosier "researcher":

The mode by which man becomes infected with Histoplasma Capsulatum remains obscure. Human cases have been so sporadic that it does not seem probable the disease spreads from person to person. The organism has not been found outside animal bodies. It has, however, been found occuring naturally in dogs. In addition, Emmons, Bell and Olson found histoplasmosis in one mouse and ten rats in a rural county in Virginia where four cases of human histoplasmosis had occurred. Such animals may serve as the natural reservoir from which man is infected.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

AID FROM THE RIGHT PLACE

The American Medical Association could not possibly spend money from its national education campaign fund any better than by allocating it, without strings attached, to accredited medical schools, which are hard-pressed financially.

Announcement that the A.M.A.'s governing body, the House of Delegates, had voted $500,000 in subsidies to 79 schools of medicine was made at the clinical session of the association, here in Cleveland.

This is aid to medical education from the right source, from the medical profession itself, instead of from the federal government; for the inevitable concomitant of federal subsidy is a steadily increasing measure of federal control.

The action by the A.M.A.'s House of Delegates is heartening. It should be copied by all who are concerned with the preservation of medical education, inquiry and research unfettered by government regulation.

Medical education in this country badly needs unrestricted operating funds and endowments, so that the administrators of medical schools may use those funds in the way in which they believe mankind will be most benefited and the nation best assured of fully qualified medical and surgical practitioners.

One may fully sense that need by referring to data on our own Western Reserve University School of Medicine, where the operating cost per student this academic year will be $3,237, as against a tuition fee of $800, which cannot practicably be raised much, if any, higher.

We like to regard such action by the A.M.A. as the beginning of the doctors' own subsidy to medical education, as evidence of new progressivism and enlightenment in the association leadership. The A.MA. is fully justified in raising funds to combat socialization of medicine, but it should not use those funds wholly in a propagandistic and negative way. Its $500,000 grant to the medical schools, which was described as "the nucleus of a fund which we hope will be greatly augmented by contributions from many other sources," is a wise and proper expenditure.

Cleveland Plain Dealer

THE SUBSIDY SNARE

The American Medical Association, which won the overwhelming support of the American electorate in its fight against the Truman Administration's effort to impose socialized medicine through a system of compulsory health insurance, has now moved to close a breach through which socialized medicine might creep in by stealth.

The association has appropriated half a million dollars for the assistance of medical schools that need money to meet their expenses or to expand their services.

* * *

The money will come out of the National Education Campaign fund—appropriately, since the fund was raised for the purpose of defending medical freedom and there is no surer way to do that than to prevent the medical schools of the country from being SUBSIDIZED BY THE FEDERAL GOVERNMENT.

"Federal subsidy," said a statement issued by the association, "has come to be a burden, not a bounty.

"It is bringing intolerable increases in taxation, and is DANGEROUSLY INCREASING FEDERAL CONTROLS OVER OUR INSTITUTIONS AND THE LIVES OF OUR PEOPLE."

That is an accurate estimate of the worth and the effect of federal subsidies.

Actually these "gifts" of federal money are not gifts at all. The money comes out of the pockets of the taxpayers, including the pockets of those who receive the subsidies.

And the price the recipients of the pretended "gifts" pay for them is THEIR INDEPENDENCE.

They surrender at least a part of their control over their own affairs to a horde of eager, arrogant federal bureaucrats, and they are exceptionally lucky if, in the long run, they do not lose their control entirely.

* * *

If the Socialists of the Truman Administration gained control of our medical colleges they would use their control to pervert medical education into an instrument for the advancement of state medicine.

The best way to make sure the Socialists do not get control is for PRIVATE ENTERPRISE to finance the medical schools, so that they will not have to accept government handouts and government control.

In its patriotic effort to do that the American Medical Association will need the help of other believers in free enterprise, and should have it in abundance.

Hearst Newspapers

REPORT CONCERNING WAR MANPOWER*

JOHN E. OWEN, M.D.†

INDIANAPOLIS

THE BACKGROUND of Public Law 779, or as it is frequently called, "The Doctors Draft," would furnish a typical example of a democracy in action. In the country's haste to beat the swords into plowshares at the termination of hostilities of World War II there was considered to be no need to conserve the manpower or material resources assembled at great cost by our country. The chief reason for this was that the UN would lead to a lasting peace. Time and events have well demonstrated this not to be true.

When world unrest became evident and the complete demobilization of the armed forces did not take place, it was necessary to have trained specialists to maintain the medical departments. Appeals for medical volunteers both by the Armed Forces and the A.M.A. met with no response. These appeals were aimed chiefly at the younger men who had received their training at government expense and had not served in the war.

A limited mobilization was decided upon and the Draft Article of 1948 was passed. P.L. 779 is an amendment of it. Inductions under this Act did not begin until it became evident that armed conflict (undeclared war) was upon us. With the expansion of the armed forces, the need for specialists, including medical aid, became an immediate problem and volunteer response was lacking.

To meet the need, an aroused Congress passed the "Doctors Draft Law." On proclamation of the President, this law requires the registration of all doctors and others up to the age of fifty and requires them to serve with the armed forces. This law expires July of this year, but is certain of either extension or re-enactment.

The provisions of the law define the specialists (in our case doctors) affected and arrange for registration and induction into the armed forces.

The registrants are broken down into four priorities, both as to registration and as to possible induction.

Priority One: All ASTP and similar program students trained at government expense, and those deferred from military duty to complete their education, who have had less than 90 days active duty.

Priority Two: Those trained as above who have had 90 or more days active duty but less than 21 months.

Priority Three: Those who have had no active duty subsequent to September 16, 1940. (This group includes those who were out of school, in practice and deferred for reasons of essentiality, health, hardship, et cetera.)

Priority Four: All those not included in priority one or two, who have had active service in the armed forces subsequent to September 16, 1940.

The law outlines the mechanism for registration, classification, examination and induction under the selective service system. It affects all doctors up to 50 who are citizens of the USA and certain aliens. Exceptions are members of reserve components of the armed forces (organized, inactive and honorary reserves), and certain aliens.

Registration was carried out on those in Priorities 1 and 2 on October 16, 1950, and on those in Priorities 3 and 4 January 15, 1951.

Physical examination of priorities 1 and 2 have been carried out and the processing of these groups is close to completion, with final classification into selective service classifications.

Induction into military service will begin whenever the flow of volunteer doctors fails to meet the requirements of the armed forces. This induction will be carried out on a national quota (not state or regional) calling the youngest registrant in Priority 1 first and proceeding through this priority and exhausting it before calling anyone in Priority 2. If Priority 1 fails to supply sufficient doctors then the second priority will be called up in the same manner.

Provisions for Priorities 3 and 4 have been arranged for by the law, but it is not probable that any action will be taken immediately in these groups unless a marked change in the armed services needs takes place.

The mechanism of the draft lies within the regular setup of the Selective Service System. Registration does not prevent volunteering of doctors for service and an additional $100.00 per month is given medical officers who volunteer. If a doctor volunteers and receives orders for induction before he receives his commission, this extra pay is not given.

Physical requirement standards of the registrants are set by the armed forces. They subject to review all physical examination reports and decide on a registrant's acceptability. At the immediate present these standards are stated to accept any doctor who can engage in the active practice of medicine and has no progressive defect. The average disqualification rate of about 4,000 of the Priority 1 group was reported as 20 percent at a meeting in Washington January 12, 1951.

The local Selective Service Boards determine the classification of the registrants.

* Presented at the Conference of County Medical Society Officers, at Indianapolis, January 28, 1951.

† Chairman, Committee on Military Manpower, Indiana State Medical Association.

As an aid to the armed forces, and as a check on the manpower distribution in the fields of individuals coming, the President designated a National Volunteer Advisory Committee to the Selective Service with authority to appoint State V.A.C. to S.S. The committees appointed are representative of the specialist groups involved by the P.L. 779.

The state committees in turn may appoint subcommittees and local committees.

In Indiana the rapid demand for some group organization in the emergency resulted in the appointment of an Indiana Committee on Military Manpower by the President of the I.S.M.A. This committee was organized at the time of the French Lick meeting and has had two meetings since.

The president of each local society has appointed a similar local committee.

Since the state V.A.C. to S.S. chairman is the chairman of the S.S. M.M.C. their action has been coordinated from the beginning.

After the first registration on October 24, a bulletin was issued to the county chairmen outlining their duties according to instructions from the selective service. The duty of the local committee is to pass on the registrants' essentiality and irreplaceability to the community.

The recommendation of the local committee will be transmitted to the local selective service boards to aid their decisions. While the committee has only advisory powers in this matter, its recommendations, if sufficiently supported by its reasons therefor, have been promised careful consideration.

The state selective service headquarters requirements for considering essentiality on registrants in Priority 1 and 2 are very clearly defined. The only physician in a community, interns, until the completion of their internship, and residents, to completion of the last year of a residency, are recommended as essential. Any others must be considered on a strictly individual basis, with any exception to the above likely to be rejected.

The state W.M. committee acts (1) as advisor on appeals from local advisory committee or selective service decisions; (2) As transmitting agency in communicating with other state advisory committees or selective service boards.

Soon all reserve officers called for active duty will be cleared through state and local committees as to essentiality in their communities, before orders will be written on them.

In order to keep abreast of the manpower situation in the communities of the state a questionnaire was sent to all local chairmen, and a request for monthly reports on the number of doctors entering the service. This is important to Indiana, as it had a ratio of 1 physician to every 928 population as of January 1, 1950. So far only part of the local committees have sent in reports. If such a lack of cooperation is indicative of the interest in this matter, half of the state will discover that "Greetings" from the selective service have taken so many doctors out of this state that the health requirements of the communities cannot be covered. This is a serious matter, as induction of physicians may begin at any time.

At the last meeting of the state W.M. committee it was agreed to have each section of the state covered by the committeeman in that area, to answer questions or aid in straightening out any problems arising.

The National Volunteer Committee has had the preservation of essential hospital medical service and medical education as a part of the problem it is facing. The only suggestions on these two points were of little assistance where Priority 1 and 2 individuals are concerned, as they are largely considered replaceable and in this respect not essential.

A frequent statement heard is that Public Law 779 will not work and that it is hoped it is not necessary to utilize it. This does not mean that the law cannot be enforced but that it would result in embarrassment and discomfort to the inductee. It can and will be enforced if necessary. The nonworkable phrase refers to the fact that selective service cannot induct a man to commissioned officer status. A commission must be requested. Therefore, any registrant inducted will have a private's rank and duties (nonprofessional) until he has made application through channels (these, as any veteran will tell you, can be long and slow) and has been accepted for commission.

SPECIFIC INFORMATION

A. Registrants:

Priority 1.

(a) Any registrant physically qualified and not in an essential classification is advised to make application for a commission at once. This advice is from the National Advisory Committee. The Medical Advisory Committee to the National Security Resources Board states that the armed forces will require all available physicians in Priority 1 by July 1, 1951, and that Priority 2 will possibly be exhausted before 1952.

(b) Interns who apply for a commission will not be ordered to duty until their internship is completed. It is suggested that they apply early.

(c) Residents, deferred to complete their last year, should apply for a commission prior to completing their residency.

Priority 2.

Processing of physical examinations and determination of classification by selective service is under way. There will be no calls for induction until Priority 1 registrants who have a 1A selective service classification have been called.

Priority 3.

Registration has recently been completed, but this group was not required to fill out S.S. questionnaire form 390 and further processing will be carried out according to the needs of the armed forces in the future.

Priority 4.

The same facts stated in Priority 3 hold so far as classification and processing of registrants is concerned. Should any of this group be considered for induction at a later time, they will be called according to the inverse number of months they have had of active duty, rather than age, as in the first three priorities.

B. RESERVES:

1. Organized Reserves:
   Subject to necessity in an emergency will only be called where unit is called.
2. Unorganized or Inactive Reserves:
   By April 1 all reserve officers will be listed and an evaluation of their essentiality to the community will be established. They will only be called after clearance with local and state committees. Subject to necessity it is intended that they will be called parallel to their counterpart in draft registration priority.

C. HOSPITALS:

It is pointed out that residencies have been increased 300 percent since 1940. A cutback to essential minimum is necessary with use of veterans, physically disqualified, and women, where they are available.

A member of the National Advisory Committee says it will be necessary for staffs of hospitals to care for their own patients to a greater degree. If sufficient medical officers become available to permit, residencies in some few critical specialties will be given to reserve officers on a deferred basis to furnish more trained men in these specialties. The army states this cannot be done at present.

SCHOOLS AND RESEARCH INSTITUTIONS:

Teachers in the basic sciences in medical schools are in short supply and should be recommended as essential. Clinical instructors in the lower priorities can only be deferred sparingly.

Research workers are to be considered on an individual basis as to experience, age, value of problem, et cetera. These may be screened through the National Committee and the National Research Council.

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Please make checks payable to
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To make the Foundation an effective force for the maintenance of medical education, it is suggested that each physician consider an annual contribution of $100. Many of the contributions already received exceed this amount. A physician who finds such a contribution beyond his means can still demonstrate his support of the Foundation with a smaller contribution.

WEIGHED IN THE BALANCE*†

HAMILTON W. MCKAY, M.D.

CHARLOTTE, NORTH CAROLINA

IT IS DIFFICULT for us to realize and visualize the revolutionary changes which have taken place in business and professional circles in the past few years. I refer to changes in the thinking of the average American, the changes which apply to the creation of an attractive environment for the public to do business in and the entirely new approach to customers from the standpoint of public relations.

The following statistics, which were released by Ralph Brubaker of the Los Angeles Sales Executive Club, indicate the reasons for the rapid changes in the thinking of the average citizen during the past ten years and show the necessity of setting our sights on a much higher level:

Since 1940

(1) 13½ million old customers have died;

(2) Over 17 million marriages have taken place;

(3) Over 30 million babies have been born;

(4) Over one-third of all present families in the United States have been formed;

(5) Out of the 140 odd million people in the United States today, 63 per cent do not remember World War I;

(6) Fifty-two per cent do not remember a Republican administration in the White House;

(7) Forty-eight per cent do not remember what conditions were like before World War II;

(8) Forty-four per cent are consciously experiencing for the first time a free market in which they can buy what they want from normal assortments.

To enlarge upon these statistics and to further indicate why this "new" thinking public has come into being, stroll through the business district of your city or town. First enter your bank. You may or may not realize it, but the bars and grill-work are demolished. Open counters and attractive surroundings replace them. Perhaps some junior officer approaches you with a smile and asks if he can serve you. These radical changes did not just happen but were brought about by the leaders in the banking business who, twenty years ago, felt a need for good public relations and did something about them. To me, modern merchandising is fascinating beyond description. The proper psychological display of merchandise will even make you buy items that you do not need. Air-conditioning, special shopping guides to aid customers, free parking for his or her convenience: you just cannot get away from it. In a modern place of business, the customer is always right or is made to think he or she is. In dealing with the great air lines of this country, you will encounter courtesy and accommodation that are revolutionary in the field of transportation. As doctors, I think it is a good idea to leave our offices and hospitals once in a while and think, as we have been thinking, about the world along Main Street, the world of bankers, merchants, hotel managers and air line representatives. I believe there is much for doctors to learn along Main Street. The great and important truth we learn is that these persons are schooled and trained in business administration, and that they believe and practice good public relations because it is essential to building for the future and success.

Today, everything is being "weighed in the balance" by the people of America. Our town is no longer an isolated little island in an agricultural sea. We hear the news of the world simultaneously with our fellow Americans everywhere. We even see the World Series games in our homes as they are played. We move across the face of the earth or fly to far away places at speeds undreamed of a very few years ago. We are linked commercially and professionally in an amazing network that crosses the boundaries of the past as if they were no longer there at all.

As a consequence, the people of America have come to expect miracles of progress as a matter of course. And woe be unto any sector of American life which fails to keep pace, for it will be weighed in the balance of public opinion and will be found wanting.

What about the world of medicine? Is it really a world apart? Or must it also take its place in this new world that we have seen on our walk along Main street? Has it any grill-work and bars which must be torn down? Does it, too, stand in need of some air-conditioning and renovating? Let us consider these questions.

Certainly we should begin by crediting our profession with the advancements it has admirably achieved. We know that it is true that more people get better medical care today in America than in any other country in the world. We know that we have a program of medical education second to none. We know that we have a system of hospitals, clinics, and medical centers, small and large, that is the envy of the whole

* President's Address, Southern Medical Association, Forty-Fourth Annual Meeting, St. Louis, Missouri, November 13-16, 1950.

† Reprinted from *The Southern Medical Journal*, Birmingham, Alabama.

world. All of these and many more are measurable facts that stand above dispute.

But the trouble with most of us is that we stop our thinking at this point. We do not realize that it is not enough to be better than somebody else. Most of the American people do not know much about the levels of medical care and attention in other parts of the world, and most of them care less. We may think our fellow citizens are ungrateful in this; but no matter how much we think it, we still cannot change the fact that they are weighing us in an altogether different set of balances.

We are being weighed against the balance of strictly American standards. Our public relations are being weighed against the public relations standards which Americans have come to respect in other pursuits. Our competence is being weighed against the American standard of competence in other professions. Our charges are being weighed against the budgetary demands of other services which are essential to life and happiness in America. What we need is a revolutionary change of direction in our own thinking. We must break from our traditional defensiveness, our backward glances at the distance we have come, our comparisons with Europe and Asia. We must accept the challenge of the American mind. We must weigh ourselves against the standards of American demands!

What, exactly, does the American public think of American medicine? I wish I knew. Actually that is a question it is impossible to answer. It would depend, for one thing, on the segment of the public you are talking about. Level of family income, geographic location, cultural background, all these and many other factors would condition the answer.

But, if you will forgive me for generalization, I will tell you that it is my opinion that something is radically wrong between the medical profession and the people of America.

True enough, the people have not yet permitted the obstructing hand of the politician to lay itself upon the free practice of medicine by the individual doctor. But the only thing that has saved us so far from political control of medicine has been the statesmanlike efforts of hundreds of unselfish medical leaders like Dr. Elmer L. Henderson, president of the American Medical Association, and his co-workers, plus the spending of huge sums of money in our defense. We are deeply grateful for the services which our leaders, teachers and practitioners are rendering wherever they may dwell. The battle is not yet won. It is only well begun.

I assume that it is as clear to you as it is to me that the loss of freedom in medical care would be an American tragedy. Why, then, is it not equally clear to the people, who, in the end, would bear individually the awful burden of the loss?

Well, it is tempting to conclude that they are simply ignorant of the consequences of socialization. It might even be comforting to us to shift the whole burden upon the people by taking the cynical position that the American spirit of self-reliance is vanishing and they are seeking collective security rather than individual responsibility in all areas of life.

To some degree, these criticisms may be justified. But I, for one, believe that they have been vastly overestimated by many medical men.

I believe, if I am correct in my premise, that there is something radically wrong between the people and the doctors; then it follows that we must be prepared to accept our rightful share of the blame for this situation.

Edward Bulwer Lytton spoke a great truth when he wrote a long time ago, "The easiest person to deceive is one's own self." Have we been guilty of self-deception? Have we been blinded to our own faults and deficiencies? Is our traditional attitude of defensiveness mute evidence of our own reaction? If so, it is high time we changed our attitudes in favor of self-analysis, correction, and a positive program of constructive public relations. Or, to express it somewhat more simply, we must bring the doctor back to the people and the people back to the doctor. This is the grassroots problem. This is the fundamental task; and unless we get on with it, medicine is sooner or later doomed to political control.

So much for generalizations. Now let us get down to some practical suggestions in the direction of these objectives.

Let us begin with medical education itself; and what better place is there to make our beginning?

Many institutions, organizations and individuals play an important role in the training of a doctor. And each one is busily and constructively engaged in current debate concerning the length of time a man should be occupied in the various stages of his medical training. Personally, I do not believe that the time can be shortened and I have no criticism to offer of the scientific training program. What I am concerned about is the lack of evidence that our educators are aware of the tremendous need for training in human and public relations.

A streamlined 1950 model of the well-trained doctor can make a difficult diagnosis and direct the therapy. If he is trained to do a lung or brain operation, he can do it well. In short, he is a first-class scientific product, "ready and willing to go." But, he has not been taught, either in medical school or in the hospital, to become a part of the the community, one of the people. There is a gulf, deep and wide, between him and his potential patients. In his office, he is like a babe in the woods. He knows little or nothing of office organization, of handling patients, or of how to charge and collect. He simply does not know that it is not enough to do a good scientific job; he is a bungling novice in the art of human relations with his patients, who are, after all, his greatest assets and medicine's stock in trade.

In the community at large, he is no better. He

tells his fellow citizens that he does not have time to help with the character-building agencies and civic enterprises that make the town or city a better place for his wife and children to live in. He believes that the Chamber of Commerce, which brings many potential patients to him and his fellow doctors, should be run and supported by laymen or somebody else. When the self-sacrificing solicitor for the Community Chest finally runs him down, he makes a token gift much as if he were tossing small change in a collection plate. Such criticism is meant to be constructive and is to emphasize the lack of training in this area rather than to belittle the young doctor.

Such conduct, in and out of the office and hospital, is well known, too, and frequently discussed by the lay people of his community. If he were the only one who suffered as a result, it might be simple justice. But, the fact is that it is just such failures in the realm of personal and public relations that have nearly cost us our medical freedom.

Somewhere along the road between admittance to a medical school and completion of hospital internship and residency, a period of twelve to fifteen years and a cost estimated between $20,000 and $35,000, provision must be made to teach the young scientist the practice of good personal and community relations. It is vital not only to his own welfare but to the future of free medicine itself.

Another area in which we have done a sorry job is in professional self-discipline. The doctor who has a license to practice medicine and joins a county medical society is usually fixed for life. Unless he is convicted by a court for some criminal offense, he can continue to enjoy the rights and privileges of responsible doctors even though he, himself, practices overcharging, neglect of patients and nonsupport of organized medicine.

Such practices should not only be considered intolerable by the good doctors, but should be condemned and properly dealt with by an honest competent and nonpartisan court of medicine. Grievance committees are now operating in more than twenty states and the American Medical Association is taking steps in the right direction. All of this constitutes one of the most interesting experiments of modern times.

A third area in which we need to clean our own house is in the medical practice acts which in many states permit doctors to carry out procedures, operative or otherwise, for which they are neither trained nor competent. I am not speaking about criminal abortion, violation of the Harrison Narcotics Act or other like offenses. Neither am I thinking about the honest mistakes that each of us makes every day. I am referring to the medical man or surgeon, usually in the small hospital, who cannot or will not make proper studies to arrive at a diagnosis or have a diagnosis made. Often these men are responsible for the health of hundreds of people.

These antiquated medical practice acts which license a man to practice medicine and surgery and give him the permission of the state to do anything on anybody, constitute another grievance against medicine; for the results of incompetence in high places of medicine and surgery are beginning to become known to the people. To illustrate, *Readers Digest* carried an article in December 1947 on this subject which must have been read by countless millions. In substance, it reported to the people "the shocking fact that many of the 9 million surgical operations performed annually in America are unnecessary."

It should be perfectly clear to anyone that if the people cannot convince themselves that organized medicine is taking vigorous steps to correct its own shortcomings, they will insist that the initiative for action be transferred to other hands.

Now, in summary, here is what we have done: we have observed wonderful progress which has been made by other groups along the Main Streets of America in overcoming serious public relations problems; we have reminded ourselves that it is not enough for us to compare the American medical system with similar systems in other parts of the world; we have seen that we are being weighed in the balance of public opinion against strictly American standards; we have recognized that something is radically wrong between the people and the doctors; we have accepted our share of the blame for this situation; and we have suggested three areas in which we should make immediate beginnings toward improvement: education in the art of human relations, professional self-discipline, and modernization of the medical practice acts.

These suggestions by no means exhaust the possibilities for progressive action. But, they do serve most capably the primary purpose of this discussion, which is to make it as clear as I possibly can that ultimate responsibility for the freedom and welfare of American medicine rests squarely upon the individual doctor and his friends in related organizations in the field of general medicine. The term "organized medicine" has no meaning except as it be defined in terms of individual responsibility. Unless and until the doctor on Main Street faces up to the deficiences of his profession and wants these weaknesses corrected, there will be no progress.

We can win the fight for medical freedom if and when we decide to look after our own business. This means sacrifice, hard work and devotion to organized medicine. Above all else, it means that liberty is possessed only by those who earn the right to be free and employ that freedom in such a fashion as to maintain and enhance the respect and confidence in which the physician is held by his community.

News Notes

DOCTOR GIORDANO HONORED

At the annual meeting of the American Society of Clinical Pathologists, in Chicago, in October, Dr. A. S. Giordano, of South Bend, was awarded the Certificate of Highest Merit and a medal, for his contributions to the science of pathology and his service to the society. This is only the second time that the certificate of Highest Merit has been awarded. Doctor Giordano was also appointed to serve on the American Board of Pathology at that meeting.

Announcement has been made of the formation of **The Indiana Psychosomatic Forum**, which is to be held the third Monday of each month, at 8:00 p.m., on the third floor of the Clinic Building, at the Indiana University School of Medicine. Anyone interested in psychosomatic medicine is invited to attend.

The American Society for the Study of Sterility will hold its seventh annual meeting at the Ritz Carlton Hotel, in Atlantic City, June 9 and 10. Registration fee for the two-day session is $10.00. For further information, address the society, at 20 Magnolia Terrace, Springfield, Massachusetts.

At a recent meeting of the **Indianapolis Obstetrical and Gynecological Society**, the following officers were elected: President, **Dr. G. W. Gustafson**, Indianapolis; Vice-President, **Dr. David A. Bickel**, South Bend; and Secretary-treasurer, **Dr. C. O. McCormick, Jr.**, Indianapolis.

TEACHING SEMINAR IN PROCTOLOGY

The International Academy of Proctology will present its first teaching seminar on proctologic subjects, including the more recent developments, in the form of a symposium and round-table discussion. The session will be held in New York City, April 7, 1951.

Registration for the seminar will be limited in number and open to licensed physicians who are members of the American Medical Association; State or County Medical Associations and graduates of an approved medical school. Admission to the seminar will be by card only. Preference in registration will be given to those affiliated with the International Academy of Proctology.

For registration or further information communicate with Dr. William Lieberman, Chairman, Seminar Committee, International Academy of Proctology, 1819 Broadway, New York 23, N. Y.

Vice Admiral Joel Thompson Boone, Medical Corps, United States Navy, Retired, has accepted appointment as Chief Medical Director of the Veterans Administration, it was announced by Carl R. Gray, Jr., Administrator of Veterans Affairs.

Admiral Boone will take over his duties at the VA by April 1, 1951. He succeeds **Dr. Paul B. Magnuson** whose resignation, previously presented, has been accepted by General Gray effective January 15, 1951.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1951 AWARD CONTEST

The National Gastroenterological Association again takes pleasure in announcing its Annual Cash Prize Award Contest for 1951. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on Gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

POSTGRADUATE COURSE IN PULMONARY DISEASES

A postgraduate course in pulmonary diseases will be conducted by the American Trudeau Society in cooperation with the Marquette University School of Medicine at Milwaukee, March 26-31, 1951. This course is intended for physicians who have special interest and training in pulmonary diseases. Fee for course is fifty dollars, ($50.00), to be paid in full at time of filing. Application forms may be obtained from Indiana Tuberculosis Association, 130 East Washington Street, Indianapolis 4, Indiana.

BONUS APPLICATIONS

The Indiana General Assembly has extended the final filing date for the Indiana World War II Veterans' Bonus until April 30, 1951.

The original law passed by the 1949 session of the General Assembly specified that all claims must be filed not later than January 1, 1951.

Applications may be obtained by Indiana residents by contacting their local county Service Officer, American Legion, Veterans of Foreign Wars, Disabled American Veterans, or the Red Cross. Out of state residents who qualify for the bonus may obtain forms by writing to Bonus Division, Indiana Dept. of Veterans Affairs, 431 North Meridian Street, Indianapolis 4.

REGIONAL MEETING INTERNATIONAL COLLEGE OF SURGEONS

On Monday, April 9, the Indiana Section of the International College of Surgeons has the privilege of being host for the Regional Meeting of the states of Wisconsin, Michigan, Ohio, Illinois, and Indiana.

The scientific meeting will be in the auditorium of the Indiana University School of Medicine. Papers will begin at 8:45 Monday morning. Discussions will be held at the end of both morning and afternoon sessions.

Luncheon will be served at noon in the Riley Hospital, at which time a pleasant surprise is in store for all attending the meeting.

Dinner at 6:30 will be at the Columbia Club. An address by Dr. Max Thorek will follow. Reservations for both luncheon and dinner should be made as soon as possible, or by March 15, through the office of Dr. W. P. Moenning, Secretary of the Indiana Section.

Among the noted speakers will be: Dr. Herbert Acuff, Acuff Clinic, Knoxville, Tenn., International President of the International College, on "The Transthoracic Approach to Upper Abdominal Problems in Surgery." Dr. A. S. Jackson, Jackson Clinic, Madison, Wisconsin, Secretary United States Chapter, on "Modern Concepts of Thyrotoxicosis." Dr. Philip Thorek, Associate Secretary, International Board of Surgery, on "Recent Trends in Esophageal Surgery." Dr. L. W. Freeman, Research Dept., Indiana University, on "Regeneration of the Spinal Cord."

The full program for the day will be announced later when all time schedules are arranged.

The Indiana Section extends a cordial invitation to all members of the Indiana State Medical Association and the Indianapolis Medical Society to attend this meeting in its entirety, including discussion of the papers, the noon luncheon, and the dinner at the Columbia Club. The illustrated address after the dinner, by Doctor Thorek, writer, artist, philosopher, surgeon, and founder of the International College, will wind up a day of unusually worthwhile papers from men of exceptional talent and experience.

The Indiana Section wishes to stress the fact that this meeting will be for the advantage of all doctors. All are invited and welcome to share in the experience of this April 9.

George Garceau, M.D.,
Regent of Indiana.

Thomas B. Noble, M.D.,
President, Indiana Section.

INDIANA ACADEMY OF GENERAL PRACTICE THIRD ANNUAL SCIENTIFIC SESSION

Athenaem, Indianapolis
April 10 and 11

APRIL 10

Registration—Athenaeum—9:00 A.M.
Technical Exhibits Open—9:00 A.M.
10:00 A.M., Meeting, Board of Directors, Athenaeum
12:00 Noon Luncheon, Board of Directors, Officers and Chairmen of All Committees, Athenaeum
1:00-1:50 P.M. George S. Bond, M.D.—Indianapolis — *"Coronary Artery Disease"* — Small Auditorium, Athenaeum
2:00-2:50 P.M. Arlie Barnes, M.D., Mayo Clinic *"The Problem of Pulmonary Embolism"*
*2:50-3:30 P.M. Inspect Technical Exhibits
3:30-4:00 P.M. Round Table Discussion—*"Cardio Vascular Renal Disease"*
4:00-5:00 P.M. Annual Business Meeting
8:00-10:00 P.M. Arlie Barnes, M.D., Mayo Clinic

"THE FOUNDERS ANNUAL LECTURE"
"The Effect of Cortisone and ACTH on Acute Rheumatic Fever"
Joint Meeting with Indianapolis Medical Society, Staff Society of the Methodist Hospital and I.A.G.P.—White Cross Guild Building, Methodist Hospital

APRIL 11

9:00- 9:50 A.M. Election of Officers
10:00-10:45 A.M. Frank B. Ramsey, M.D., Indianapolis *"Hyperthyroidism, Comparative Treatment with Medicine, Surgery and Radio-Active Isotopes"*
10:45-11:30 A.M. Gordon W. Batman, M.D., Indianapolis *"The Orthopedics That a General Practitioner Should Do"*
*11:30-12:00 Noon Inspect Technical Exhibits
12:00 Noon All I.A.G.P. Luncheon—Athenaeum Representative, Headquarters Office American Academy of General Practice—Speaker
1:00- 1:50 P.M. William E. Gabe, M.D., Indianapolis *"Gynecology"*
2:00- 2:50 P.M. J. P. Greenhill, M.D., Chicago *"Recent Progress in Gynecology"*
3:00- 3:50 P.M. Hayworth N. Sanford, M.D., Chicago *"Problems in the Care of the Newborn"*
*4:00- 4:30 P.M. Inspect Technical Exhibits
4:40- 5:00 P.M. *Question and Answer Period* Speakers of the Day Participating
6:30 P.M. *Banquet*—Athenaeum
Mr. Ralph L. Lee—Public Relations Department of General Motors, Nationally Famous Speaker, Engineer, Author, Pilot, Minister, Musician, Salesman and Industrial Researcher, *"People as They Come and Are"*

A very capable Women's Committee is working to prepare a fine program for the ladies. Complete announcement of the details of this Program will be made.

A.M.A. WASHINGTON OFFICE NEWS

Civilian Members of Armed Forces Medical Policy Council Announced. Three civilians who will complete the Armed Forces Medical Policy Council are: *Dr. I. S. Ravdin* of Philadelphia, professor of surgery at University of Pennsylvania; *Dr. W. Randolph Lovelace II* of Albuquerque, N. M., a trustee of Lovelace Clinic; and *Dr. James P. Hollers* of San Antonio, Texas, practicing dentist and former officer of American Dental Association. Dr. Richard Meiling is chairman of the Council and other members are the three Surgeons General. With Dr. Howard Rusk's Health Resources Advisory Committee of National Security Resources Board, the Council will advise Defense Department on number of reserve physicians, dentists and veterinarians who may be called to active duty at any one time without endangering the health of the civilian population. It will not participate in selection of individual reserves, this being a function of the National, State and Local Advisory Committees to Selective Service.

Military: S. S. National Advisory Committee has this general advice to *interns* and *residents*: Interns even in Priority I will be allowed to finish out year, but better volunteer for reserves by June 1. Same applies to *Priority I residents*, who are further cautioned not to expect to continue their residencies through next year. Situation uncertain for *Priority II residents and interns;* best general information is that few will be called in next *six* months, many in *subsequent three months* . . . Three Army nurses from Korea are pepping up Nurses Association-AMA-Army drive for more nurses . . . Difficulties are being encountered with some employers in areas where impact of new reserve training directive is being tested. Under new rule, reserves in organized Army units or on troop basis (in direct support of combat troops) *must report for summer training*, regardless of their own or employers' wishes. A few employers have threatened to fire men who take the time off . . . *Rear Admiral Lamont Pugh* has been sworn in as Navy Surgeon General, replacing Rear Admiral Clifford Swanson. Admiral Pugh's post as deputy Surgeon General has been taken over by Rear Admiral Clarence J. Brown.

One Out of Five Doctors Failed to Pass Physical Tests. Of the doctor-draft physicians examined so far, about one out of five failed to pass Army's physical examination. The rate for physical or neuropsychiatric reasons is 19 per cent for doctors as against 17.4 per cent for regular draftees. Army lists the major causes for physician rejections as tuberculosis, duodenal ulcers, neuropsychiatric ailments, hypertension and severe asthma. *Six per cent of those found below par are being taken into service on a waiver of their disability, lowering the per eent not eligible to about 13 per cent.*

All cases of physicians rejected for physical reasons must be reviewed by a special military medical board here in Washington, which has greater authority in accepting questionable cases than the induction stations.

An Army spokesman expressed the opinion that *the rejection rate for physicians was about what might be expeeted.* It was pointed out that the induction examinations the men now are undergoing actually are more severe than those they had to pass in World War II before being admitted to the Army as ASTP students. Also, the men are from five to ten years older than the average draft registrant, a factor which would tend to increase the rejection rate.

Navy Establishing 24-week Course for Doctors Going on Active Duty. With 31 enrolled in the first class, Navy has started a new *24-week* indoctrination course for doctors coming on active duty. Eventually, Navy hopes to detail all men coming on duty for the first time to this training. The bulk of newly commissioned Navy doctors currently get essential orientation with the unit or hospital to which first assigned. The plan is to substitute the new 24-week course for this on-the-job training. In contrast, new Army doctors are put through a six-week course at Fort Sam Houston, Texas, prior to assignment to units or special duty. At the start of the Korean war, Army cut its indoctrination of some doctors to as little as three days. Under the 24-week Navy course, about half the time is spent in special study at Naval Medical Center, Bethesda, the rest in field training with Marines, aboard submarines and airplanes and with amphibious units. A Navy spokesman said it would be two or three years before the full scope of the program is determined.

Deaths

Karl T. Brown, M.D., of Muncie, died after a long illness on January 30, at the age of seventy-six. He was a graduate of the Barnes Medical College, of St. Louis, in 1899, and had practiced in Crawfordsville, and San Antonio, Texas, before entering the service in World War I. After his military service, he established practice in Muncie, where he had practiced his specialty of otolaryngology ever since. Doctor Brown was an Honorary member of the Delaware-Blackford County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Richard H. M. Bayley, M.D., of Lafayette, died suddenly on January 18, at the age of fifty-nine. A graduate of the University of Michigan Medical School, in Ann Arbor, in 1920, he had practiced in Lafayette ever since that time. Doctor Bayley was a member of the Tippecanoe County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

John J. Connelly, M.D., of Terre Haute, died suddenly on January 12, at the age of sixty. He had practiced in Terre Haute since 1924, specializing in ophthalmology and otolaryngology. He was a veteran of World War I. Doctor Connelly graduated from the University of Louisville School of Medicine, in 1913, and had practiced in Kentucky and in Rockville before entering military service. He was a member of the Vigo County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Emil G. Grove, M.D., of Shelbyville, died on January 26, after a long illness. He was seventy-eight years of age. After graduating from the Keokuk Medical College, in Iowa, in 1896, he began the practice of medicine in Fairfield, Iowa, in 1898, moved to Morristown in 1939, and established a practice in Shelbyville in 1941. Doctor Grove was a member of the Shelby County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Horace M. Powell, Jr., M.D., of Indianapolis, died on January 14, at the age of twenty-seven. He was a graduate of Johns Hopkins Medical School in 1949, and was a veteran of World War II. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

A. Lonzo Ratcliff, M.D., of Kingman, died on January 8, at the age of seventy-eight. He graduated from the Illinois Medical College, in Chicago, in 1905, and had practiced in Kingman for forty years. Doctor Ratcliff was an Honorary member of the Fountain-Warren County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Henry R. Vandivier, M.D., who had practiced in the vicinity of Terre Haute for more than half a century, died on January 19, at the age of eighty-one. He graduated from the Medical College of Indiana, in Indianapolis, in 1898, and practiced in Clay City until 1918, when he moved to Terre Haute. Doctor Vandivier was an Honorary member of the Vigo County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

William H. Wiseheart, M.D., of Colfax, died on January 12, following a brief illness. He was eighty-seven years of age. A graduate of the Central College of Physicians and Surgeons, in Indianapolis, in 1897, he had practiced in Colfax for fifty-two years, until his retirement, two years ago. Doctor Wiseheart was an Honorary member of the Clinton County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Warren R. Hickman, M.D., of Logansport, died on January 29, after a short illness. He was forty-five years of age. He was a graduate of Indiana University School of Medicine, in 1930, and was a veteran of World War II. Doctor Hickman had practiced his specialty in ophthalmology and otolaryngology in Logansport since 1933. He was a member of the Cass County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

George D. Anthoulis, M.D., of Gary, was killed in an automobile accident on January 17, at Porter. He was sixty-three years of age. He graduated from the National University of Athens School of Medicine, in Greece, in 1912, and had been practicing in Gary since 1916. Dr. Anthoulis was a member of the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

January 14, 1951

The Council of the Indiana State Medical Association convened for its midwinter meeting at 10:20 A.M. Sunday, January 14, 1951, in the Harrison Room of the Columbia Club, at Indianapolis, with Dr. W. U. Kennedy, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Paul D. Crimm, Evansville, alternate
Second District—William C. Reed, Bloomington
Sam I. Rotman, Jasonville, alternate
Third District—William H. Garner, New Albany
Fourth District—Charles Overpeck, Greensburg
Fifth District—V. Earle Wiseman, Greencastle, alternate
Sixth District—W. U. Kennedy, New Castle
Seventh District—Roy A. Geider, Indianapolis
Don E. Wood, Indianapolis, alternate and co-chairman, Legislative Committee
Eighth District—E. H. Clauser, Muncie
T. R. Hayes, Muncie, alternate
Ninth District—Wemple Dodds, Crawfordsville
Harry E. Klepinger, Lafayette, alternate
Tenth District—William H. Howard, Hammond
Eleventh District—Elton R. Clarke, Kokomo
Twelfth District—M. B. Catlett, Fort Wayne
Myron L. Habegger, Berne, alternate
Thirteenth District—Kenneth L. Olson, South Bend

Officers:

Alfred Ellison, South Bend, president
J. William Wright, Indianapolis, president-elect
Roy V. Myers, Indianapolis, treasurer
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL
A. W. Cavins, Terre Haute, associate editor of THE JOURNAL
Walter L. Portteus, Franklin, chairman, Executive Committee
C. J. Clark, Indianapolis, member, Executive Committee
Albert Stump, attorney
Ray E. Smith, executive secretary
James A. Waggener, field secretary

Guests:

Don E. Wood, Indianapolis, and
Norman R. Booher, Indianapolis,
co-chairmen, Legislative Committee
Cleon A. Nafe, Indianapolis, chairman, Indiana A.M.A. Campaign Coordinating Committee
J. Neill Garber, Indianapolis, chairman, Committee on Convention Arrangements
Glen Ward Lee, Richmond, chairman, Committee on Civilian Defense
James O. Ritchey, Indianapolis, chairman, Committee on Publicity
Neal E. Baxter, Bloomington, chairman, Committee on Maternal and Child Health
Senator Walter F. Kelly, Indianapolis
J. V. Cassady, South Bend

Minutes of the Council meetings held on September 25 and 27, 1950, at French Lick were approved as printed in the November, 1950, issue of THE JOURNAL, with the following additions to the list of those present at the September 27 meeting:

Myron L. Habegger Berne, alternate councilor, Twelfth District
Kenneth L. Olson, South Bend, councilor, Thirteenth District.

District Meetings

District meetings are scheduled as follows for 1951:

First District
Second District
Third District—New Albany,
Fourth District—North Vernon, May 16
Fifth District—Terre Haute, May 9
Sixth District—Liberty, May 10
Seventh District—Indianapolis, May
Eighth District
Ninth District—Lafayette, May 24
Tenth District—Whiting, April 12
Eleventh District—Peru, May 16
Twelfth District—Fort Wayne, May 17
Thirteenth District—South Bend, November

REPORTS OF OFFICERS

Dr. Alfred Ellison, President 1951 "I am very pleased to tell you gentlemen that our group of committees is doing a very outstanding job this year. It seems to me that we have been very fortunate in having an unusually good selection of committeemen, and I am glad to tell you that the important committees—of course they are all important—but the ones whose functions mean so much, especially at this time, are having numerous meetings—and are turning in a job of which we are very proud. I wrote the chairmen of the committees in December, asking them to render a report to us so that it could be discussed at this meeting. If anything were contemplated that would involve a matter of policy, it could come before this Council. As you realize, there are three policy-making bodies of the association, the Executive Committee, the House of Delegates, and this Council. Committees, on occasion in the past, have taken action or expressed something to the public which represented a matter of policy, which these policy-making bodies had not approved, and sometimes these mat-

ters were contrary to the attitude of these bodies. And so, I thought it well to make these committeemen aware of this fact, and at the same time invited them to send a report to us so that whatever was contemplated in their activities could be discussed here in the light of a new policy, perhaps. We have, as you know, thirty-seven committees, and of this number there were twenty-three to whom it seemed proper to address such a letter, and of these, we have had reports from twenty-two already. The other report I am sure will be in. So you can see that that is a good start.

"I want to call to your attention, if I may, the work of some of these committees especially, to make you aware of what they are doing and if you see in their activities any divergence from the policies that you feel should be followed, you can express yourself and we can make the committee people aware of this attitude so they can correct it.

Activities of Rural Health Committee

"The first committee I want to talk about is the Rural Health Committee. This committee has been an exceptionally active one. It has been active somewhat in the past; it has done a good job, but I think that this year you are going to agree that their work will be outstanding, not only in the matter of pure rural health perhaps, but in the matter of public relations. Now, one of the things that they are undertaking is to help communities in Indiana who need doctors to find that doctor, and they have already set about to do that. They have already contacted all the junior and senior students in the medical school. They have made an interesting survey of these students to find out what percentage of them want to do general practice, and we are pleased to know that reports indicate that 8 to 1 intend to do general practice. They found also that 6 to 1 of them intend to practice in the rural areas, or would be willing to do so if they had the proper facilities with which to practice there, namely, some laboratory facilities and an x-ray machine for diagnostic fracture work, and so on. And that was encouraging to this committee.

"They have started out on a new departure which apparently is not in conflict with any other ideas that the society has had. They have had one trial flight of this idea up in St. Joseph County, and it, briefly, is this. Their intention is to go to each of the Indiana University Extension Centers and put on a course of instruction there, to be given by doctors near or resident in that community, upon popular medical topics. This plan is being started, as I say, in the South Bend area, and it promises to be a very good thing. The enrollment so far has been encouraging, the topics have been well chosen, and so forth. Does anybody see any objection to that sort of a contemplated program? We think it has great promise of doing good.

"Now another thing that they are active in is the continuation of the interest in the county health councils, which have been rudderless, somewhat, in a great many counties. The organization had been perfected and then it sort of floated around because no one seemed to know just what direction to put it in, and they are undertaking to guide these county organizations. In an effort to do that they hope to establish a State Health Council. That has been done, as you know, in some of the states and if it is done properly it seems to be a very excellent means of promoting this program.

"They plan to continue with the conference that is sponsored by Purdue, hoping to take a more active part even than they have in the past.

"Then another thing that they have been doing actively is to have interviews with various people in the rural areas in an effort to find out in substance: what is rural health, what's wrong with it, what does it need? All in all, we feel that this committee is doing an excellent job. I don't believe there is anything in this activity that would raise a question in our minds about its propriety.

Committee on Physician-Hospital Relationship

"Now there is another committee which came about as a result of the so-called Hess committee's work with which you probably are familiar. This has to do, as you know, with the relationships between doctors and hospitals. It's a very, very important thing at this time because we have recently become aware of the fact that hospitals by and large, not any particular hospital, but the American Hospital Association, shall we say, has very definite ideas to the effect that hospitals may ethically employ physicians on a wholesale or salary basis, if you please, and resell their services on a fee basis. There is no doubt about the fact that they have that attitude, since it has been published in their publications. It is such a serious matter and has such far-reaching implications that the American Medical Association two years ago took recognition of this trend and appointed, as you know, this so-called Hess committee. They brought in an initial report which was questioned by the A.M.A. Council as to its legality because it had some restrictions upon hospitals which continued to offend. This matter was reviewed again for another whole year and the report brought in again at this last session in San Francisco. The upshot of it is that the Hess committee has recommended, and it has been approved now by the A.M.A. House of Delegates, that it be entirely unethical for any physician to be employed by a corporation, hospital or otherwise, on a salary and have that institution resell his services on a fee basis. Now, that's the gist of the Hess report, and it has such far-reaching implications that the A.M.A. has requested that each state have a committee to deal with the philosophy of this matter. In accordance we did set up such a committee which is known as the Physician-Hospital Relations Committee, and

they have set about a very elaborate, ambitious program to try, firstly, to educate the doctors on this thing. We find there are a great many physicians who are unaware, in the first place, of this threatened encroachment and unaware of the attitude that the A.M.A. has taken, unaware of the real significance of this trend. We feel that it isn't a one-year proposition, but it's a long-term program of education, firstly, of the doctors, and secondly, of hospital administrators, and thirdly, of the hospital trustees. And to do that they have adopted various methods. One of them is to send out a questionnaire to the various doctors in Indiana who come under this threat. Those physicians in Indiana who are thusly threatened with this type of socialization, of course, are the anesthetists, the x-ray men and the laboratory men. And so it is to these men that they are addressing these questionnaires to awaken them to this problem and moreover to get their own reaction to their particular situation. As you know, a lot of these men are located in communities that have carried on through precedent, a program that actually is in violation of the philosophy of this Hess report and they are quite happy in that relationship. It is obvious to everybody concerned that you just can't go in and say, with an iron first, that 'You can't do that any longer.' This thing has to be a gradual transition, an evolution, if you please, instead of a revolution. And so we feel that this committee's activities are very important. They contemplate, also, talking to medical students about this.

"Now, another thing that this committee hopes to work on is the matter of insurance in Indiana, the matter of Blue Shield and Blue Cross. As you know, when Blue Shield was originated the promise was made to the physicians of Indiana that as soon as this company got on its feet financially, the payment of laboratory, anesthetic and x-ray fees would be taken over by Blue Shield, on the basis, of course, that these are professional services and should not be paid for by the hospital insurance but rather by the personal Blue Shield insurance. They hope to follow this matter along and see if something can't be done along that line. Is there anything in the program of this committee's activities that seems to you to be contrary to any policies that you might have in mind? If there is, we would like to know it so that it can be altered.

"Now, the Public Relations Committee is working under somewhat of a handicap. Their budget isn't at all what they would like to have to accomplish some things they want to do, and I think when the Budget Committee meets maybe we can look into that situation.

Civil Defense

"There is a matter that I think all here today should think about, and that is this matter of civil defense. We are going to have a report later on, as you know, from the chairman of that committee. You may well realize that this thing has been a little sluggish, that the public even has been clamoring for a little more activity, not only upon our part but upon the part of federal and state officials in this matter. But at long last the federal office has brought out a booklet which they are printing now to sell for sixty cents, or in quantities of 100 or more at forty-five cents, which has as its intention explaining to the people what to do in the case of an atomic bombing. It is the intention of this federal office to supply each county with one of these copies. We should think about the possibility of our state organization purchasing a quantity of these booklets and, upon request by any of our members, he be given a copy. This notice could go to all the doctors through various means—our bulletin, in THE JOURNAL, and so on. So let's think about that today and when this committee reports we can perhaps take some action on this.

Socialized Medicine

"I think you ought to be reminded of the fact that while socialization of medicine on a national scale is apparently halted at this time for a brief spell, we must not relax. These planners are long-range fellows, they are out to socialize us eventually and they don't care how many years it takes. I think we must not, for a moment, relax our vigilance. We must not, however, allow that to interfere with our patriotic duty now that this country is threatened with a very serious disaster.

Public Relations

"It seems to me that one of the most important things, and it certainly would be the most important thing, if we didn't have this war threat, is our own public relations. I am amazed when I talk to my lay friends how they feel toward doctors. They like individual doctors, yes, but doctors as a whole are at a new low in the esteem of the public. I think we had better recognize this and admit it and try to do something about it. Now, this is an old story, you say; but it isn't an old story. If we are going to improve it, we have got to face it, and if we are going to face it, we might as well do it now instead of next year, or the year afterwards, because these things get progressively worse. There are various methods by which we can do that, and of course the very first thing to do is to get our own house in order. Under that heading we might agree that doctors are no different from plumbers or bakers or anybody else. We have a certain percentage of our membership that are a little bit on the rascal side and will be glad to take advantage of a situation if they have the chance to. Now that percentage, I believe, has been estimated by psychologists and people who work in this field around 3 percent of the public. You know very well that we have men who overcharge when occasion offers a chance, we have men who treat the public poorly when they are called on for service, and we have men who

render poor service. Now, one of these fellows can undo all the good that all you men can do in a whole day's time of driving for miles and miles to come here. One of these fellows can undo more good than you can create in this day's work. You know that. Examples of these things come into the state office week after week, and some of them are almost unbelievable.

"I have the very firm conviction that we should republicize through the press of the state of Indiana the fact that we do have this so-called Grievance Committee. We had much publicity of that thing in the press when the committee was first appointed, as you remember, and nothing that we have done has ever created a more favorable reaction on the part of the public than that program. The mere publication of the existence of that committee created more favorable comment on the part of the public and especially newspaper people than any other one endeavor that we have ever gone into, and I think that the public should be constantly reminded that this committee exists.

"We don't do this as a punitive thing against anybody, of course. We think it is a great deterrent if the erring doctor knows that this committee exists. Of the many grievances that do come in, there are only a few that have real merit. The committee in the past has seen fit to call some of these men in and to talk the thing over with them, and the program has great possibilities for good. I think that it is one of the best things we have ever done along that line, and I think we should republicize it in the press. I think that with the connections that Ray and Jim have with the press that this publicity could be handled very well. I want to ask you gentlemen of the Council, do you approve of doing this thing, of re-inaugurating this education program in the press? If you do, will you say 'Aye'? . . . The ayes have it. Does anyone want to squelch that sort of a thing, keep it sub rosa, and so on; if you do, speak up. Otherwise, let's do that, gentlemen, let's promote that.

Fee Schedule

"There are various things on public relations, of course—I shouldn't take the time to go into some of them. As you know, the state of Colorado, has adopted, or has asked each county to adopt, a fee schedule, and to publish that fee schedule in the press so that the people will know that an appendix operation under normal circumstances is going to be so many dollars, just like the price of an automobile. If you went in and bought an automobile and drove it out and got a bill a week later for $6,000 instead of the three that you thought it was going to cost, you would feel pretty ill about the automobile business, wouldn't you? And so, that's the way it goes with our fees, and I think the thing has some merit. It restores a measure of confidence once more in the public. It gives them some degree of confidence so that if they do have such an emergency come up their expenses are going to be just so much and not an unpredictable thing that frightens them.

"Now, along that line, I have a program on which I would like to ask your advice, a thing which I propose to do if you approve it. I think it has great merit. It would be comparatively inexpensive. I don't believe it would cost more than $200 to accomplish this. I would propose to write a letter, a personal letter which would not be mimeographed but typed on a special Hooven machine, I believe you call it, which creates letters which you can't tell from a personally typewritten letter, and I would propose to send these letters to, we'll say, 400 or 500 representative Hoosier citizens. And in this letter we would very simply, very humbly state that we have one hope in writing to them and that is to help this common situation. The wording of the letter has not been formulated but the gist of it would be that we realize that there has been some criticism of the medical profession, that the organization of physicians is extremely anxious to do what it can to correct such feeling, that we would appreciate it indeed if they would take time to write us a letter and tell us their opinions of our shortcomings. Also, what we might do to improve our services, or to correct some of these things that they hear talked about, and finally, leave them with the impression that we have one ambition only and that is to arrive at something that will be good for our profession and for the public. I think this project would have two or three outstanding merits. One would be that it would immediately create in the minds of these representative citizens the feeling that we were honest and straightforward in approaching this problem, that we were sincere in wanting to do something to correct these shortcomings. It would have splendid public relations value, I feel. Secondly, it would provide us with specific information about some of these complaints and thirdly, provide us with material with which we could then go to our membership and say 'Here is really what the public is thinking about us.' It would give us tangible and concrete evidence with which to work in considering the solution of this vitally important matter. It is the feeling of many of us that these misdoings cannot continue indefinitely without all of us paying the penalty for it. I am convinced that somebody is going to correct this thing and if we do not do it ourselves the people may welcome the Government stepping in. I think we had better do it before the Government has a chance to. I think this matter is acutely serious. Some states, as you know, have gone to great lengths to help correct their public relations; they have employed special talents to do nothing but that, to make surveys and so on, and at a very great expense. We can profit indeed by the findings that they have made. They are published. We have them, and those things will help us, too.

"Now, I would like to ask you gentlemen if you approve of sending out these letters or not. My

feelings won't be hurt at all. I personally feel that it is a good thing to do, and I have talked to several people about it, both lay and professional, and I have yet to find anybody, except one or two, who has any hesitation to say that it is a good thing to do. One or two feel that we might be a little more subtle, that we had better not do this sort of thing. But, gentlemen, we have got to face this matter and begin to do something. I wonder, if I might ask, please, for some expressions about this, if you care to? Does anybody object to it? Does anybody have any idea about it?"

Following discussion by Drs. Reed, Dodds, Overpeck, Garner and Crimm, on motion of Drs. Howard and Reed, the Council approved the sending of a letter on Dr. Ellison's presidential stationery and over his signature, to four or five hundred representative Indiana citizens, asking them to tell the medical profession what it can do to improve its services and to correct its faults.

Dr. Roy B. Myers, treasurer, presented the following report, compiled by George S. Olive and Company, certified public accountants, which was accepted on motion of Drs. Geider and Dodds:

TREASURER'S REPORT

January 11, 1951

The Council,
Indiana State Medical Association,
Indianapolis, Indiana

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1950, and the statements of income and expense, and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets, all funds, and related statements of income and expense, on the basis of cash received and disbursed, present fairly the position of the Indiana State Medical Association at December 31, 1950, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Yours very truly,

Geo S. Olive Co.
Certified Public Accountants

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION
Analysis of Increase in Assets, All Funds,
Year Ended December 31, 1950

TOTAL ASSETS, DECEMBER 31, 1950		**$75,298.29**
TOTAL ASSETS, DECEMBER 31, 1949		**72,678.56**
NET INCREASE		**$ 2,619.73**
Arising from the following sources:		
Excess of operating cash disbursements over operating cash receipts, general fund, year ended December 31, 1950:		
Receipts—		
Exhibit C	$129,562.82	
Disbursements—		
Exhibit C	132,993.32	
		$(3,430.50)
Excess of operating cash receipts over operating cash disbursements, The Journal of the Indiana State Medical Association, year ended December 31, 1950:		
Receipts—		
Exhibit D	39,316.67	
Disbursements—		
Exhibit D	35,632.42	
		3,684.25
Excess of operating cash receipts over operating cash disbursements, Medical Defense Fund, year ended December 31, 1950:		
Receipts—		
Exhibit E	4,642.75	
Disbursements—		
Exhibit E	5,276.77	
		(634.02)
Add: Purchase of U. S. Savings bonds	2,000.00	
Increment from U. S. Baby bonds	1,000.00	
		2,365.98
NET INCREASE		**$ 2,619.73**

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION
Statement of Assets, All funds,
at December 31, 1950

GENERAL FUND:		
Cash on deposit—Exhibit C		$ 5,533.51
Petty cash fund		500.00
Investments:		
Indianapolis City Hospital bonds	$ 4,000.00	
U. S. Treasury bonds	5,000.00	
U. S. Savings bonds	32,000.00	
		41,000.00
Total general fund		$47,033.51

THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:			
Cash on deposit—Exhibit D			8,507.08
MEDICAL DEFENSE FUND:			
Cash on deposit—Exhibit E		1,757.70	
Investments:			
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	13,000.00		
		18,000.00	
Total Medical Defense Fund			19,757.70
TOTAL ASSETS, ALL FUNDS—Exhibit A			$75,298.29

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION
Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1950, and December 31, 1949

General Fund

	Year Ended December 31, 1950	Year Ended December 31, 1949	Increase (Decrease)
CASH BALANCE AT BEGINNING OF YEAR	$ 8,964.01	$ 16,195.94	$(7,231.93)
RECEIPTS:			
Membership dues	117,682.50	53,300.00	64,382.50
Income from exhibits	7,938.50	15,080.00	(7,141.50)
Interest income	1,112.50	1,165.00	(52.50)
Postgraduate study fees	430.00		430.00
Proceeds from matured bonds	1,000.00		1,000.00
Krannert Nurse Scholarship fund	1,200.00		1,200.00
Egbert Medical Scholarship fund	100.00		100.00
Centennial book fund	63.30	357.20	(293.90)
Instructional courses	36.02	239.94	(203.92)
A. M. A. campaign fund		17,000.00	(17,000.00)
Checks written off and miscellaneous refunds		17.50	(17.50)
	129,562.82	87,159.64	42,403.18
BEGINNING BALANCE PLUS CASH RECEIPTS	138,526.83	103,355.58	35,171.25
DISBURSEMENTS:			
Transfer of applicable portion of dues to The Journal of the Indiana State Medical Association—Exhibit D	11,004.00	14,213.00	(3,209.00)
Medical Defense Fund—Exhibit E	4,327.75	2,691.00	1,636.75
Purchase of securities	1,000.00		1,000.00
Headquarters' office expense	21,106.05	26,837.25	(5,731.20)
Publicity committee	730.37	1,068.44	(338.07)
Public policy	6,846.60	2,265.62	4,580.98
Council	1,105.31	1,076.55	28.76
Officers	2,897.51	3,538.79	(641.28)
Annual session	7,399.85	17,865.81	(10,465.96)
Miscellaneous committees	9,898.97	14,363.03	(4,464.06)
Federal insurance contributions tax	217.78	139.63	78.15
Indiana unemployment compensation and excise tax	435.58	483.38	(47.80)
Refunds of dues	38.00		38.00
Refunds of exhibit rent	77.50		77.50
Fifty-year Club	35.04	176.91	(141.87)
Increase in petty cash fund		300.00	(300.00)
Woman's Auxiliary to I.S.M.A.	218.35	800.00	(581.65)
Indiana A.M.A. Campaign Coordinating Committee—	64,883.75	8,511.55	56,372.20
American Medical Association dues	612.50		612.50
General practitioner award	58.10	60.61	(2.51)
Miscellaneous	100.31		100.31
	132,993.32	94,391.57	38,601.75
CASH BALANCE AT END OF YEAR	$ 5,533.51	$ 8,964.01	$(3,430.50)

(Exhibit B)

Exhibit D

INDIANA STATE MEDICAL ASSOCIATION
Statement of Cash Receipts and Disbursements, Year Ended December 31, 1950

The Journal of the Indiana State Medical Association BALANCE, JANUARY 1, 1950		$ 4,822.83
RECEIPTS:		
Subscriptions—members—Exhibit C	$11,004.00	
Subscriptions—non-members	409.00	
Advertising	27,115.13	
Collections on accounts receivable	355.15	
Single copy sales	210.99	
Electrotypes	222.40	
Total receipts—Exhibit A		39,316.67
		44,139.50
DISBURSEMENTS:		
Salaries	7,400.00	
Printing	24,664.07	
Office postage	320.24	
Journal postage	624.19	
Advertising commissions	51.30	
Electrotypes	937.36	
Press clippings	50.75	
Editor and editorial board expense	291.56	
Office supplies	156.93	
Rent	480.00	
Electricity	22.08	
Telephone and telegraph	209.67	
Federal insurance contributions	106.52	
Indiana unemployment compensation and excise tax	213.00	
Miscellaneous	104.75	
Total disbursements—Exhibit A		35,632.42
BALANCE, DECEMBER 31, 1950—Exhibit B		$ 8,507.08

Exhibit E

INDIANA STATE MEDICAL ASSOCIATION
Statement of Cash Receipts and Disbursements, Year Ended December 31, 1950

Medical Defense Fund

BALANCE, JANUARY 1, 1950		$ 2,391.72
RECEIPTS:		
Transfer of applicable portion of dues from the general fund—exhibit C	$ 4,327.75	
Interest income	315.00	
Total Receipts—exhibit A		4,642.75
		7,034.47
DISBURSEMENTS:		
Malpractice fees	1,476.77	
Attorney fees	1,800.00	
Purchase of U. S. Savings bonds	2,000.00	
Total disbursements—exhibit A		5,276.77
BALANCE, DECEMBER 31, 1950—exhibit B		$1,757.70

Dr. Frank B. Ramsey, editor of THE JOURNAL: "As you have heard from the treasurer's report, the financial condition of THE JOURNAL during 1950 is much improved. We have been able to operate during the year with a few thousand dollars to the good. Mr. Smith thinks that if we can continue to do that during the first half of this year we probably will be able to pay back from the JOURNAL's fund the $3,000.00 which was advanced to us during the centennial year.

"There is one other thing that I would like to mention. What Doctor Ellison said about the splendid work of these committees reminds me of it. Several of the state journals over the country put in what they call committee pages. They will devote one single page to the report of some special committee, as Doctor Ellison pointed out, such as the Rural Health Committee, that has done some special kind of work or has some new kind of program which would profit by having a good deal of publicity out to each individual member. Doctor Cavins last year suggested that we adopt that, and we have, not with the idea of having a committee page each month but having one whenever a committee had something particularly suitable, and I would like to make the announcement of that fact. Mr. Waggener has been talking to me about the work of the Rural Health Committee. It appears that it might be a good thing to publicize their program a good deal, even while their program is being started, before it achieves any results. The fact that doctors all over the state might help it along, might gain a good deal of material to help the pages when new things come up. At any time that any of these committees have any announcements or any program to outline, THE JOURNAL will be very glad to make a committee page. We will try to encourage not filling the entire page as tight as it can be filled because, as you know, in advertisements sometimes we achieve much greater results if the space is not filled but is only partially filled, with a lot of light space in between the print. And if we can, we would like to fill that space rather loosely so that it appears a little different from the rest of THE JOURNAL and it is a little more readable."

On motion of Doctor Dodds, seconded by several, the Council approved the management of THE JOURNAL during the past year.

At this time it was taken by consent that a message of condolence and affection be sent to Dr. A. M. Mitchell, Terre Haute, councilor of the Fifth District, who is ill.

ELECTIONS FOR 1951

1. *Chairman of the Council.* Dr. W. U. Kennedy was re-elected unanimously chairman of the Council for 1951.

2. *Executive Committee members.* On motion of Drs. Reed and Geider, Dr. W. L. Portteus and Dr. C. J. Clark were re-elected members of the Executive Committee for 1951.

UNFINISHED BUSINESS

1. *Report of Special Committee on Income Pension Plan.* As a matter of information to the Council, Dr. Elton R. Clarke, chairman, read a letter from Frank J. Viehmann, state insurance commissioner, in which Mr. Viehmann gave approval to the Independence Plan of the Jefferson National Life Insurance Company, the plan accepted by the Council at its meeting on July 16, 1950. Doctor Clarke then read a letter written by Doctor Ellison to Henry J. Peirce, president of the Underwriters Association, in answer to objections of some insurance agents to the plan.

2. *Report of Special Committee on Disability Insurance.* Doctor Catlett, chairman, reported that his committee would have another meeting as soon as Mr. Stump, attorney for the association, receives descriptions of policies from all of the disability insurance companies that were contacted.

3. *Report of Indiana A.M.A. Campaign Coordinating Committee.* Doctor Nafe, chairman, presented for the consideration of the Council the following things which he said his committee feels should be done during 1951:

(1) The speaking campaign against compulsory health insurance should be continued on a somewhat limited scale.

(2) The state medical association should sponsor a constructive pamphlet campaign on education of the public, what they should do in case of a bombing, or in case of emergencies, etc. The A.M.A. Campaign Committee would be glad to cooperate with the Committee on Publicity in this endeavor.

(3) The committee should carry on a constructive educational campaign in a dignified fashion,

probably putting out three or four statewide newspaper paid educational releases of about one-fourth page each on what medicine stands for and what it has done. This would require from $25,000 to $30,000, based on what was spent on the 1950 advertising campaign.

(4) The committee recommends that it be given a budget of $50,000 for 1951. (On motion of Doctor Howard, duly seconded, the Council approved a $50,000 budget for Doctor Nafe's committee for 1951.)

4. *Report of Special Committee to Consider Invitation of Indianapolis Medical Society to Share Quarters with It at 2902 N. Meridian Street, Indianapolis.* Doctor Reed, a member of this committee, reported that a meeting of this committee had not yet been held.

1951 ANNUAL SESSION AT INDIANAPOLIS

1. *Dates set by Executive Committee*—Monday, Tuesday and Wednesday, October 29, 30 and 31, 1951.

2. *Report of Committee on Convention Arrangements.* Dr. J. Neill Garber, chairman, presented a brief outline of plans for the session, as follows:

Headquarters—Murat Temple.
Monday evening—Smoker for the men. Entertainment for the women, either jointly or separately.
Tuesday evening—Entertainment.
Wednesday evening—Annual dinner.
Budget—probably between $5,000 and $6,000 would be adequate.

3. *Budget.* On motion of Drs. Reed and Catlett, the Council appropriated $6,000.00 to the Committee on Convention Arrangements.

4. *Section or general meetings?* The secretary read a letter from Dr. L. H. Allen, chairman of the Section on Obstetrics and Gynecology, asking that his section be permitted to hold "a definite clinical program at the next meeting . . . to encourage better practice in our field."

On motion of Doctor Myers, duly seconded, the Council voted to continue with the present plan of having only general scientific meetings during the annual session, with each section being given the privilege of selecting one speaker and having that speaker appear at a luncheon meeting of the section in addition to presenting a paper on the general program.

5. *General outline of program,* including the foregoing suggestions, follows:

Monday, October 29, 1951

Morning
Registration
Instructional courses
Technical and scientific exhibits
Annual golf tournament
Annual trap and skeet shoot
Council meeting
Editorial Board meeting

Afternoon
Instructional courses
House of Delegates' meeting

Evening
Supper, smoker and stag party
Women's entertainment

Tuesday, October 30, 1951

Morning
Breakfast meetings of various groups
General scientific meeting

Noon
Luncheon meetings of sections
Class and fraternity get-togethers and luncheons
Veterans' luncheon

Afternoon
General scientific meeting

Evening
Entertainment

Wednesday, October 31, 1951

Morning
Breakfast meetings of various groups
General scientific meeting
Final meeting of House of Delegates
Final Council meeting

Noon
Luncheon meetings of sections

Afternoon
General scientific meeting

Evening
Annual banquet

MEMBERSHIP PROBLEMS

1. *1950 membership report by districts:*

County Society	No. M.D.'s in County	Members Dec. 31, 1950	Members Dec. 31, 1949	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District									
Posey	13	12	14	−2			2		
Vanderburgh	206	184	187	−3	8	5	17	5	3
Warrick	15	9	9		2		6		
Spencer	10	8	10	−2	1		1		
Perry	11	11	12	−1			1	1	
Gibson	26	22	27	−5	2		1	2	
Pike	9	8	10	−2			3	1	
Total	290	254	269	−15	13	5	31	9	3
2nd District									
*Knox	52	45	49	−4	2	1	2	3	1
Daviess-Martin	33	24	26	−2	7		2	1	
*Sullivan	24	19	20	−1	2		5	1	
Greene	22	21	21				1		
Owen-Monroe	51	49	47	2	1	1	1	1	
Total	182	158	163	−5	12	2	11	6	1
3rd District									
Lawrence	31	27	30	−3	1		4	2	
*Orange	14	14	14			1	1		
Crawford	4	4	4				1		
*Washington	10	9	10	−1			1	1	
Scott	7	4	4		1		2		
Clark	31	24	24		6	3	2	1	
*Floyd	35	32	35	−3	1	1	2	1	1
*Harrison	9	7	11	−4	2				
Dubois	19	13	18	−5	5	1	1		
Total	160	134	150	−16	16	6	14	5	1





"... it was discovered that Dramamine ... is a powerful preventive of motion sickness."

—Editorial: Dramamine,
GP 2:27 (July) 1950

DRAMAMINE®

BRAND OF DIMENHYDRINATE

—for the prevention and/or treatment of motion sickness

For the dizziness, nausea or vomiting caused by motion, Dramamine has given unusually satisfactory results, prophylactically and therapeutically. Supplied in 50 mg. tablets and in liquid form. G. D. Searle & Co., Chicago 80, Illinois.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE SEARLE

County Society	No. M.D.'s in County	Members Dec. 31, 1950	Members Dec. 31, 1949	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
4th District									
*Bartholomew-Brown	33	26	30	−4	1	1	2	1	3
Decatur	17	14	15	−1	1		2	1	
Jackson	20	17	18	−1	1		1	1	1
*Jennings	10	8	8		2	1	2		
Ripley	15	11	12	−1	2		2		
Jefferson	24	20	19	1	3		1		
Switzerland	4	4	6	−2					
*Dearborn-Ohio	18	16	16		1				1
Total	141	116	124	−8	11	2	10	3	5
5th District									
*Parke-Vermillion	29	25	25			1	3	1	
Putnam	20	18	20	−2			1	1	1
*Vigo	135	121	121		4	3	3	6	5
Clay	14	11	12	−1	1		2		
Total	198	175	178	−3	5	4	9	8	6
6th District									
Hancock	19	16	18	−2	3				
*Henry	40	38	38		1				1
*Wayne-Union	82	72	75	−3	3	1	9		3
Rush	14	12	12		1		1		
*Fayette-Franklin	28	26	22	4		3	3	2	
Shelby	29	24	21	3	1		4	1	
Total	212	188	186	2	9	4	17	3	4
7th District									
*Hendricks	21	17	19	−2	2				2
*Marion	978	861	855	6	61	75	74	19	19
Morgan	22	17	20	−3	3		1	2	
*Johnson	23	20	19	1	2	1		1	1
Total	1044	915	913	2	68	76	75	22	22
8th District									
*Madison	98	91	94	−3	4	2	5	2	2
*Delaware-Blackford	119	109	103	6	4	10	8		3
*Jay	23	19	21	−2	3		2		
Randolph	26	23	25	−2	2		1	1	
Total	266	242	243	−1	13	12	16	3	5
9th District									
*Benton	13	11	10	1	1		1		
*Fountain-Warren	18	18	17	1		1	1		
*Tippecanoe	106	97	100	−3	4	6	5	2	
*Montgomery	35	28	29	−1	3	1	4	1	
*Clinton	31	28	28		1	2	3		
Tipton	16	13	12	1			3		
Boone	27	23	22	1	1	1	3	1	
Hamilton	26	22	24	−2	1		3		2
White	7	4	4				1		2
Total	279	244	246	−2	11	11	24	4	4
10th District									
*Lake	332	295	296	−1	17	12	26	1	4
*Porter	27	24	27	−3	1		1	1	
*Jasper-Newton	22	18	20	−2	1		5		
Total	381	337	343	−6	19	12	32	2	4
11th District									
Carroll	11	10	11	−1				1	
Cass	44	37	36	1		2	6		2
Miami	24	19	19		3	1			2
Wabash	27	20	23	−3	4		3		
Huntington	26	24	23	1	1			1	1
Howard	44	38	43	−5			4	2	2
Grant	59	49	53	−4	6		5	3	
Total	235	197	208	−11	14	3	18	7	7
12th District									
LaGrange	8	8	7	1		1			
Steuben	16	11	10	1	2		3		
*Noble	26	26	27	−1			3	1	
DeKalb	23	21	21		2	1	1		
*Whitley	16	12	12		1		2	1	2
*Allen	217	196	198	−2	12		11	2	9
*Wells	34	30	29	1	1	2	6		
*Adams	19	19	19				1		
Total	359	323	323		18	4	27	4	11
13th District									
LaPorte	70	65	66	−1	2		4		
St. Joseph	217	192	191	1	13	5	12	1	3
*Elkhart	93	83	85	−2	5	1	9	1	
Starke	8	6	6		2				
Pulaski	7	7	9	−2				1	
Fulton	14	12	13	−1			1	1	
*Marshall	26	23	26	−3	2		1		1
Kosciusko	21	14	17	−3	3		3	1	
Total	456	402	413	−11	27	6	30	5	4

SUMMARY BY DISTRICT

1st District	290	254	269	−15	13	5	31	9	3
2nd District	182	158	163	−5	12	2	11	6	1
3rd District	160	134	150	−16	16	6	14	5	1
4th District	141	116	124	−8	11	2	10	3	5
5th District	198	175	178	−3	5	4	9	8	6
6th District	212	188	186	2	9	4	17	3	4
7th District	1044	915	913	2	68	76	75	22	22
8th District	266	242	243	−1	13	12	16	3	5
9th District	279	244	246	−2	11	11	24	4	4
10th District	381	337	343	−6	19	12	32	2	4
11th District	235	197	208	−11	14	3	18	7	7
12th District	359	323	323		18	4	27	4	11
13th District	456	402	413	−11	27	6	30	5	4
Total	4203	3685	3759	−74	238	147	314	81	77

* Physicians are listed in the counties in which they hold membership, not in the counties in which they reside.

22 physicians received membership gratis in 1950 because of military service.

211 physicians were senior members in 1950.

2. *Protest to the A.M.A. against collecting dues from senior members.* Following explanation and discussion by Doctor Portteus, chairman of the Executive Committee, the Council voted "to enter a strong protest to the American Medical Association against the collecting of dues from senior members who are exempt from payment of dues in the state association."

3. *Remission of state dues.* In accordance with the amendment to Chapter XI, Section 12, which

MEAT...and the ANABOLIC PROCESSES

Providing generous amounts of complete protein essential to the anabolic processes of the human organism, meat is an outstanding protein food for maintaining not only nitrogen equilibrium but also positive nitrogen balance in the patient.

Only in the past two decades has been established the full significance of adequate protein nutrition for supporting the anabolic processes of the organism in physiologic stress.[1] The healing of all types of wounds, repair of regenerating parenchymal organs, detoxification, maintenance of normal fluid balance between the various compartments of the body, growth of replacement tissue in extensive burns, rapid manufacture of antibodies, normal phagocytic response, upkeep of the erythrocyte mass and plasma protein, and support of the enzyme systems are but some of the physiologic processes dependent upon the state of protein nutrition in the patient.

Due to the almost complete absorption of the digestion products of meat protein and its excellent indispensable amino acid balance, the protein of meat participates efficiently in the synthesis of new tissue protein. On the other hand, studies in liver regeneration after partial hepatectomy have shown that incomplete proteins of vegetable origin, fed alone, do not increase the protein of the impaired liver any better than a diet containing no protein.[2]

The high content of biologically complete protein, however, is not the only reason for including liberal amounts of meat in the dietaries of patients requiring a high protein intake. Meat is also an important rich source of iron and valuable amounts of essential vitamins—thiamine, riboflavin, and niacin, and the newly discovered vitamin B_{12} which, among its several functions, promotes the most efficient utilization of protein.

(1) Ravdin, I. S., and Gimbel, N. S.: Protein Metabolism in Surgical Patients, J.A.M.A., 144:979 (Nov. 18) 1950.

(2) Vars, H. M., and Gurd, F. N.: Role of Dietary Protein in Experimental Liver Regeneration in Nitrogen Balance Study, Am. J. Physiol., 151:391 (Dec.) 1947.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



American Meat Institute

Main Office, Chicago... Members Throughout the United States

was passed at the 1950 annual session, reading as follows:

> "In the event the county society remits a member's dues for good cause, and the secretary of a county medical society recommends in writing the remission of the state association dues of said member of the society, and shows good cause why such recommendation should be granted, the Council shall have power to remit such dues,"

the secretary presented a list of names that had been submitted to the state headquarters office. Most of these names had been certified by the county medical society secretaries, but a few of them had come direct from the member or from someone other than the county society secretary.

On motion of Doctor Reed, duly seconded, the Council voted to remit the dues of all of those who had been certified by the county society secretary. Those names that did not come through the member's county medical society were to be referred to the respective county societies for action.

4. *Age for eligibility to senior membership.* On motion of Doctors Catlett and Reed the Council voted to recommend to the House of Delegates that Article IV, Section 4, of the Constitution be amended, placing the age at which a member is entitled to senior membership at seventy years rather than the present seventy-five years.

LEGISLATIVE MATTERS

Doctor Wood, co-chairman of the Committee on Public Policy and Legislation, discussed legislation of interest to the medical profession pending in the legislature and presented the following points for consideration of the Council:

1. Since the Legislative Committee is not a policy-making group, it would like to have a committee appointed or designated to which it could turn for guidance when matters involving the association's policies present themselves. (On motion of Drs. Howard and Reed, the Council authorized the Executive Committee to advise with the Legislative Committee as to official policies of the state association and to set policies in legislative matters.)

2. *Resolution regarding national compulsory sickness insurance.* Doctor Wood asked that the action taken by the House of Delegates at the 1950 French Lick meeting, in passing a resolution authorizing the Legislative Committee to have introduced in the state legislature a resolution directing the eighty-seventh General Assembly to memorialize Congress "to refrain from imposing upon the citizens of the nation any form of compulsory insurance, or any system of medical care designed for national bureaucratic control," be rescinded, due to changing times, etc. (On motion of Drs. Geider and Olson, the Council voted to omit the introduction of this resolution in the Indiana legislature.)

3. *Bill to establish School of Optometry at Indiana University at Bloomington.* Dr. J. V. Cassady, South Bend, president of the Indiana Academy of Ophthalmology and Otolaryngology, presented the following statement in opposition to the bill to be introduced in the legislature which, if passed, would create a school of optometry at Indiana University at Bloomington:

To the Councilors of the Indiana State Medical Association:

The executive committee of the Indiana Academy of Ophthalmology and Otolaryngology, being a representative organization of the eye physicians in this state, has had brought to its attention the fact that a bill is to be presented before the state legislature creating a school of optometry at Indiana University. This group is opposed to the enactment of such legislation for the following reasons:

1. We are now in a period of dire national emergency. All our resources and abilities should be directed toward the expansion of our medical school, inasmuch as there is an increasing need for physicians. A school of optometry will not provide a solution to this very salient fact. The organization of such a school of optometry will detract from this needed expansion.

2. Indiana now has no shortage of optometrists. The state is geographically situated in close proximity to one of the three recognized optometric schools in this country.

3. Contrary to the facts presented by the proponents of this bill, such a school to be adequate would require physical equipment, teaching personnel, and clinical facilities amounting to a considerable expenditure of public money.

4. It is understood that the entire curriculum would be handled at the Bloomington campus. The clinical facilities of this community would scarcely lend itself for adequate teaching of refraction or the recognition of eye diseases.

J. V. Cassady, M.D.
W. R. Hickman, M.D.
Byron L. Lingeman, M.D.
E. O. Alvis, M. D.
Myron Harding, M.D.
R. J. Masters, M.D.
E. W. Dyar, M.D.
E. L. Van Buskirk, M.D.

On motion of Drs. Olson and Catlett, which motion contained the four reasons presented by Doctor Cassady, the Council went on record as being opposed to this legislation and directed the Legislative Committee to make an effort to defeat this bill.

4. *Bill making possible the use of state funds for local health units.* This legislation was approved by the House of Delegates some time ago. Dr. Walter F. Kelly, Indianapolis (serving as a state senator), discussed his opposition to it.

NEW BUSINESS

1. *Indiana Inter-Professional Health Council.* On motion of Drs. Howard and Clarke, Dr. E. H. Clauser and Dr. William C. Reed were reappointed to serve as members of the Committee on Indiana Inter-Professional Health Council for 1951.

2. *Committee on Civil Defense.* Doctor Lee, chairman, discussed the medical phase of the civil defense program and the organization within the state. He called attention to a booklet covering this subject which is to be distributed to every county civil defense committee.

On motion of Drs. Ellison and Catlett, the Council approved the purchase of 100 copies of this booklet, entitled "Health Services and Special Weapons Defense," for distribution upon request to the members of the association.

3. *Committee on Publicity.* Doctor Ritchey, chairman, spoke of the educational pamphlet campaign

The "estrogen preferred by us is 'Premarin,' a mixture of conjugated estrogens, the principal one of which is estrone sulfate."

Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

In treating the menopausal syndrome with "Premarin," Perloff* reports that "Ninety-five and eight tenths per cent of patients treated with 3.75 mg. or less daily obtained complete relief of symptoms"; also, "General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Thus, the sense of "well-being" usually imparted represents a "plus" in "Premarin" therapy which not only gratifies the patient but is conducive to a highly satisfactory patient-doctor relationship.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

"PREMARIN" ®

"Premarin" contains estrone sulfate plus the sulfates of equilin, equilenin, β-estradiol, and β-dihydroequilenin. Other α- and β-estrogenic "diols" are also present in varying amounts as water-soluble conjugates.

Estrogenic Substances (water-soluble) also known as Conjugated Estrogens (equine)

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proposed by the Committee on Publicity, in cooperation with the Indiana A.M.A. Campaign Coordinating Committee. These pamphlets would deal with such subjects as what to do in case of a bombing disaster and in cases of emergencies, etc., and a quantity would be sent to each member of the association to be given to patients. By consent the Council approved of such a program and of the working together of the various committees in projects of this nature.

4. *Committee on Maternal and Child Health.* Doctor Baxter, chairman, gave each member present an outline of the programs approved or being sponsored by his committee. These include:

(1) Establishment of premature care training center on Indiana University Medical Center campus.

(2) Setting up demonstration unit for rooming-in care at Indiana University Medical Center.

(3) Cooperating with the Indiana State Board of Health on approved programs in the fields of conservation of vision and hearing.

5. *Nominations for Editorial Board.* Doctor Catlett nominated Dr. Richard H. Miller, Fort Wayne (surgery). Additional nominations are to be made at the next Council meeting.

6. *Spring meeting of the Council.* The next meeting of the Council will be held on Sunday, April 29, 1951.

There being no further business, the meeting was adjourned.

EXECUTIVE COMMITTEE

January 13, 1951.

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; Alfred Ellison, M.D.; J. William Wright, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guest: John P. Davey, O.D., Indianapolis.

It was taken by consent that the Executive Committee would hold a special meeting after adjournment of the Council on Sunday, January 14, to elect the chairman of the committee for 1951. (Meeting held as planned and Dr. Walter L. Portteus was re-elected chairman.)

On motion of Drs. Wright and Ellison, statements of receipts and expenditures for November and December for the association committees and THE JOURNAL were approved.

Membership Report

Number of members December 31, 1949	3,759
Number of members December 31, 1950	3,685*
Loss over last year	74

*Includes 22 in military service (gratis)
165 $10 members (residents and interns)
211 senior members

Number of AMA members, 1950	2,737

Treasurer's Office

Auditor's report. On motion of Drs. Wright and Clark, the auditor's report was accepted.

Letter from Dr. A. F. Weyerbacher, treasurer of the association from 1932 to 1950, thanking the association for the gift of a wrist watch was read.

1951 Annual Session, Indianapolis, October 29, 30 and 31, 1951

Dates. After the executive secretary explained that the dates of October 8, 9 and 10, 1951, might be available, it was taken by general consent that the announced dates of October 29, 30 and 31, 1951, be retained for the next annual session.

Legislative Matters

Local:

On motion of Drs. Ellison and Kennedy the committee voted to not oppose a bill to be sponsored by osteopaths which would permit osteopaths with unlimited licenses to refer welfare patients to tax supported hospitals for treatment.

After Doctor Davey had discussed the bill which would establish a School of Optometry at Indiana University, to be sponsored in the 1951 legislature by the optometrists of Indiana, on motion of Drs. Clark and Kennnedy the matter was referred to the Council for determination of association policy.

On motion of Drs. Wright and Clark, purchase of legislative service of the Indiana Taxpayers Association for $25.00 was approved.

National:

Letter from the Federal Security Agency, Food and Drug Administration, regarding the association's request that permission be granted pharmacists to refill prescriptions for non-dangerous drugs without procuring a second prescription from a physician was read.

Organization Matters

Payment of AMA dues by senior members. On motion of Drs. Clark and Wright, the Executive Committee voted to recommend to the Council that the association protest to the American Medical Association its action in requiring senior members who are still in practice to pay AMA dues.

Advance meeting agenda. The committee voted to discontinue the supplying of meeting agenda prior to the time of meeting, on motion of Drs. Clark and Ellison.

Budget Committee meeting. The committee voted to meet as a budget committee on Saturday, January 27, 1951, at 6:30 p. m.

Indiana Advisory Committee on Education. The president was authorized to designate some person to represent the association on the Indiana Advisory Committee on Education, on motion of Drs. Kennedy and Wright. (The president designated Dr. Donald E. Wood, Indianapolis.)

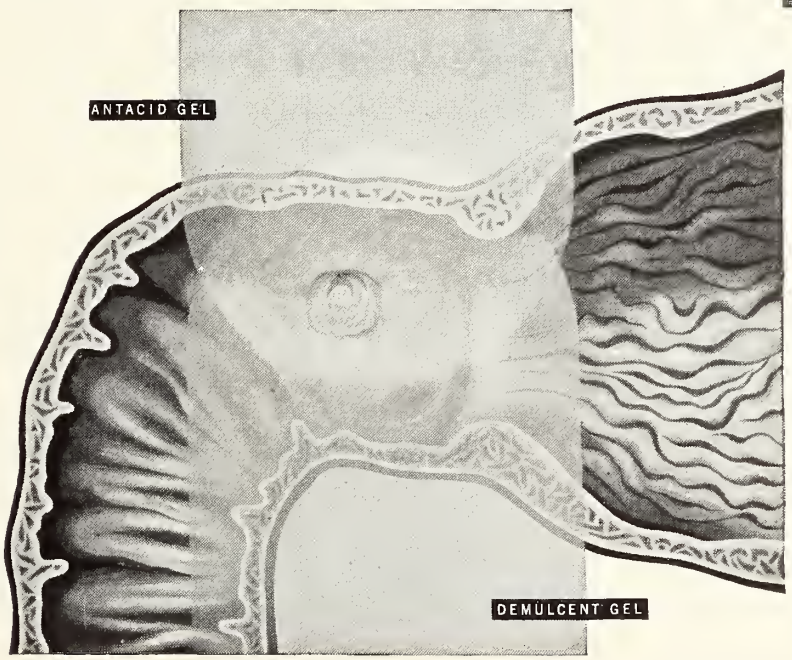
New office equipment. On motion of Drs. Ellison and Clark, the executive secretary was authorized to purchase an electric typewriter and new membership files for the headquarters office.

Funds for medical schools. On motion of Drs. Ellison and Wright, the committee voted against the state association putting on a campaign to raise funds for medical schools.

Membership in American Public Health Associa-

Only AMPHOJEL has Double-Gel Action quickly reducing gastric acidity to non-corrosive levels . . . providing a protective, soothing coating for the ulcer crater.

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AMPHOJEL Has Many Important Advantages

for the successful medical management of acute or chronic peptic ulcer. These include:

1. Relieves pain in minutes
2. Promotes healing of the ulcer crater in a matter of days
3. Does not interfere with digestion
4. No untoward effect on normal body metabolism—no acid rebound, no alkalosis
5. Does not inhibit the action of antispasmodics or laxatives if and when these are indicated
6. Safe to take for long periods of time
7. Pleasant and convenient to take
8. Economical

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tion. On motion of Drs. Ellison and Clark the executive secretary was directed to renew his membership in the American Public Health Association at a cost of $7.00.

Red Cross blood processing center. On motion of Drs. Clark and Wright the committee voted that the association should cooperate with the Red Cross in opening a center in Indianapolis where whole blood may be processed into dried plasma for use of the armed forces and civilians in event of an atomic attack.

State Conference on Social Work membership. Membership in the Indiana State Conference on Social Work at $10.00 for 1951 was approved on motion of Drs. Clark and Wright.

On motion of Drs. Clark and Kennedy the committee went on record as approving the suggestion that the State Children's Hospital at South Bend be opened to private patients providing the St. Joseph County Medical Society and the local hospitals in South Bend gave approval to the proposal.

Funds for National Foundation for Infantile Paralysis. Letter from the Marion county chapter of the National Foundation for Infantile Paralysis requesting a contribution was tabled.

The Journal

Report on advertising:

Total advertising, January, 1951____$ 2,172.60
Total advertising, January, 1950____ 2,183.17
Total advertising, year 1950_____ 27,080.81

On motion of Drs. Ellison and Clark, the price of THE JOURNAL for physicians excused from paying state dues was set at $3.00 per year instead of the previous fee of $5.00.

There being no further business, the committee adjourned to meet again on Sunday, March 18, 1951.

COMMITTEE ON PUBLICITY

December 15, 1950.

Present: J. O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; D. S. Megenhardt, M.D.; Ray E. Smith, executive secretary, and Jas. A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of Feb. 4, 1951—"Abdominal Pain."
Week of Feb. 11, 1951—"Watch that Fire."
Week of Feb. 18, 1951—"Live with Diabetes."
Week of Feb. 25, 1951—"Epilepsy."

The secretary presented a layout for a suggested pamphlet on Atomic Bombing, which could be distributed by the physicians to their patients, and stated that the cost of printing 200,000 would approximate $2,500. It was also pointed out that the State Dental Association, Blue Cross and Blue Shield, and the State Hospital Association were interested in cooperating in this matter, and had indicated their willingness to pay the cost of printing additional copies in order to make the total distribution approximate one million. The committee approved the plan in principle and referred the matter to the Council for approval of the expenditure of funds.

COUNTY MEDICAL SOCIETY OFFICERS

CARROLL COUNTY MEDICAL SOCIETY
President, Charles L. Wise, Camden
Secretary-Treasurer, Thomas C. Brown, Delphi

DEARBORN-OHIO COUNTY MEDICAL SOCIETY
President, J. K. Jackson, Aurora
Vice-President, F. D. Houston, Lawrenceburg
Secretary, Charles Manley, Rising Sun
Treasurer, F. A. Streck, Lawrenceburg

DECATUR COUNTY MEDICAL SOCIETY
President, Russel M. Blemker, Greensburg
Vice-President, E. A. Porter, Westport
Secretary-Treasurer, James C. Miller, Greensburg

FLOYD COUNTY MEDICAL SOCIETY
President, N. A. Wolfe, New Albany
Vice-President, A. M. Baker, New Albany
Secretary-Treasurer, D. H. Cannon, New Albany

GREENE COUNTY MEDICAL SOCIETY
President, John Woner, Linton
Vice-President, Kenneth Broshears, Linton
Secretary-Treasurer, J. A. Graf, Bloomfield

HAMILTON COUNTY MEDICAL SOCIETY
President, Robert F. Harris, Noblesville
Vice-President, James W. Griffith, Sheridan
Secretary-Treasurer, Leo F. Connoy, Westfield

HARRISON COUNTY MEDICAL SOCIETY
President, Guy D. Baker, Crandall
Vice-President, Louis H. Blessinger, Corydon
Secretary-Treasurer, Wilfred J. Brockman, Corydon

JACKSON COUNTY MEDICAL SOCIETY
President, J. M. Black, Seymour
Vice-President, John W. Ripley, Seymour
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LOCAL SOCIETY REPORTS

Clay County Medical Society members held a meeting at the Elks Home in Brazil on January 16. Seven members were present.

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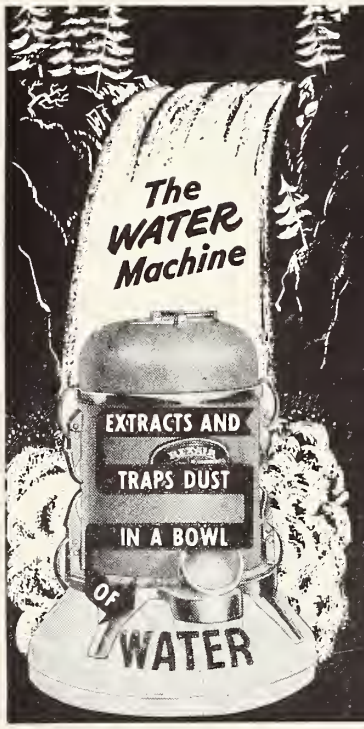
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Greene County Medical Society members, held a meeting on January 11 at Linton. Fourteen members were present to hear Dr. B. B Raney, of Linton, speak on "Obstetrics in Small Hospitals."

Harrison County Medical Society members held election of officers at the County Hospital in Corydon on January 11. Dr. W. E. Amy completed forty years as secretary of the society.

Huntington County Medical Society members participated in the telephone postgraduate seminar on January 2. Eighteen members were present.

Jasper-Newton County Medical Society members met at the Brook Hotel in Brook on January 10, when Dr. Richard E. Gery, of Lafayette, was the guest speaker. His subject was "Peptic Ulcer." Twenty-seven members and guests were present.

Madison County Medical Society members met at the Anderson Country Club, in Anderson, on January 15. Dr. J. H. Warvel, of Indianapolis, spoke on "Newer Aspects On Treatment of Diabetes." Forty-five members were present.

Montgomery County Medical Society members met at the Culver Union Hospital in Crawfordsville on January 18. Dr. W. C. Anderson, of Indianapolis, showed a film on "Self Examination of the Breast." Twenty-four members were in attendance.

Morgan County Medical Society members met at the Memorial Hospital in Martinsville on January 24. This was a business meeting and nine members were present.

Noble County Medical Society members met on January 2 at Kendallville, to participate in the telephone postgraduate seminar. Four members were present.

Orange County Medical Society members held a business meeting on December 5 at West Baden. Eight members were present.

Ripley County Medical Society members met on January 9 at Batesville. This was a business meeting and nine members were present.

Vanderburgh County Medical Society members held a meeting in Evansville on January 9, at which time they voted their unanimous endorsement of Dr. Paul D. Crimm, of Evansville, as a candidate for president-elect of the state association at its annual meeting in Indianapolis next fall. More than one hundred members were present for installation of the new officers for 1951. A program of civil defense, and winning the support of labor unions against socialized medicine, was announced.

Vigo County Medical Society members held installation of officers at their annual dinner meeting in the Terre Haute House on January 9. The society passed a resolution in honor of Dr. Albert M. Mitchell, who has been secretary of the society for thirty years. Approximately seventy members were present.

Wabash County Medical Society held a meeting on January 17 at the Wabash Country Club. Plans were discussed for securing tape recordings of postgraduate courses, as well as for the participation of the society in the local Red Cross blood bank program.

Wayne-Union County Medical Society members met on January 11 in Richmond. Dr. Jene R. Bennett, of South Bend, was the guest speaker. His subject was "Fluid and Electrolyte Balance."

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. D. E. Lybrook, Galveston.

President-elect—Mrs. F. M. Fargher, Michigan City.

Corresponding Secretary—Mrs. E. W. Bailey, Logansport.

Recording Secretary—Mrs. H. P. Sloan, New Albany.

Treasurer—Mrs. Robert Bolin, Elkhart.

Publicity—Mrs. F. M. Gastineau, Indianapolis.

SEVENTH ANNUAL HOUSE OF DELEGATES MEETING

April 26-27, Terre Haute

Vigo County Auxiliary enthusiastically urges the members of The Woman's Auxiliary to the Indiana State Medical Association to make plans to attend this House of Delegates session April 26 and 27 at the Terre Haute House.

Following a meeting with Mrs. Lybrook on Jan. 10, the Committee on Local Arrangements met at the home of Mrs. Robert Schumaker, President of the Vigo County Auxiliary, to prepare "A Calendar of Events" to be presented to the state Executive Board members for their approval. This tentative program was presented to the Board at a meeting in Indianapolis, January 24, by Mrs. Hubert Goodman, First Vice-President of the State Auxiliary. The Executive Board approved the plans submitted.

Registration at 9:30 AM, Thursday, will start the two-day session. The Board meeting is scheduled for 12:30, and since the program does not include a Thursday luncheon it is suggested that those attending the Board meeting eat enroute unless they plan to arrive earlier. The General Business session will begin promptly at 2:30 PM. Dinner is set for 7:00 P.M., with Dr. W. W. Bauer, Director of Health Education of the AMA as the guest speaker for the evening. A musical interlude will precede the fashion review to complete the dinner program.

On Friday morning the Buffet Breakfast will include a Memorial Service, arranged by Mrs. H. W. Bopp of Terre Haute. The continuation of the General Business session will follow at 10:00 AM. Luncheon, scheduled for 1:00 PM, includes plans for a national speaker, after which the General session will be completed and the Post House of Delegates Board will meet.

Mr. Ellis, manager of the Terre Haute House, has arranged for the check-out time to be between 6 and 7 PM Friday.

Reservations are now open, a number have already been confirmed. *It is requested that Presidents, President-Elects and Delegates make reservations at the earliest possible date.* Guests are cordially invited and must register also. Please make reservations by name as well as county when mailing them in to the Terre Haute House, and do have them in *by April 1.* Each county is entitled to one delegate for each 25 members or fraction thereof, in addition to the President and President-Elect.

A card for Breakfast, Luncheon and Dinner reservations will be inclosed with the official House of Delegates information mailed you at a later date. Please cooperate and mail them in promptly.

Vigo County Auxiliary is anticipating a record registration since Terre Haute is centrally located in the state.

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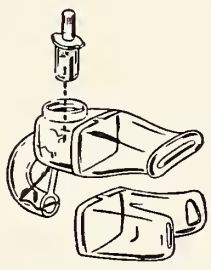
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1. Krasno, L., and Rhoads, P. (1949), The Inhalation of Penicillin Dust; Its Proper Role in the Management of Respiratory Infections, Amer. Prac., 11:649, July.

INDIANA STATE BOARD OF HEALTH
Division of Communicable Disease Control

MONTHLY REPORT—JANUARY 1951

Disease	Jan. 1951	Dec. 1950	Nov. 1950	Jan. 1950	Jan. 1949
Chickenpox	367	341	177	341	681
Diphtheria	5	7	4	26	38
Dysentery, bacillary	2	1	0	4	0
Impetigo	1	2	0	5	3
Influenza	51	97	21	53	134
Infectious hepatitis	4	3	3	0	0
Measles	211	191	37	211	267
Meningitis,					
Unclassified	7	8	3	5	9
Influenzal	1	1	2	2	3
Meningococcal	5	1	2	6	4
Pleomorphia	1	0	0	0	0
B. Coli	1	0	0	0	0
Meningococcemia	1	0	0	1	0
Mumps	167	82	90	183	193
Paratyphoid	1	2	1	1	0
Pneumonia	54	74	62	51	83
Poliomyelitis	5	35	105	11	4
Rabies in animals	19	33	43	29	83
Rheumatic fever	1	1	1	2	3
Rubella	8	13	2	23	12
Scabies	2	0	14	0	4
Scarlet fever	178	124	62	192	250
Septic sore throat	8	1	0	2	0
Tetanus	1	0	1	0	0
Tinea capitis	5	22	21	1	5
Tuberculosis,					
Pulmonary	141	139	162	221	238
Other forms	13	11	14	7	16
Tularemia	1	7	4	1	1
Typhoid fever	2	2	2	6	3
Whooping cough	89	180	151	100	80

BOOK REVIEW

PSYCHIATRIC SECTIONS IN GENERAL HOSPITALS. By Paul Haun, M.D., assistant professor of Psychiatry, Georgetown University Medical School, Washington, D.C. 80 pages. Price $4.00. Architectural Record, F. W. Dodge Corp., 119 West 40th Street, New York 18, New York, 1950.

Psychiatrists have long been aware of the need for the psychiatric section in the general hospital. Communities, too, are beginning to realize that to serve the community adequately, such a section must be included in the hospital.

Doctor Haun discusses the reason for a psychiatric section in a general hospital, how to plan one, how to work with the architect and just what facilities are needed. His analysis of the good and bad points of eight floor plans is even more valuable.

The final part of the book consists of actual floor plans for a hypothetical general hospital of 200 beds, containing a psychiatric section for both sexes. These plans, illustrating an ideal unit, were contributed by architects Charles Butler and Addison Erdman.

The hospital administrator who is contemplating the addition of a psychiatric unit should not attempt construction without a thorough study of this book. The utilization of principles outlined by Doctor Haun will make a psychiatric unit not just a building to house patients but a controlled environment which will perform a definite function in the rehabilitation of the psychiatric patient. M. F. G.



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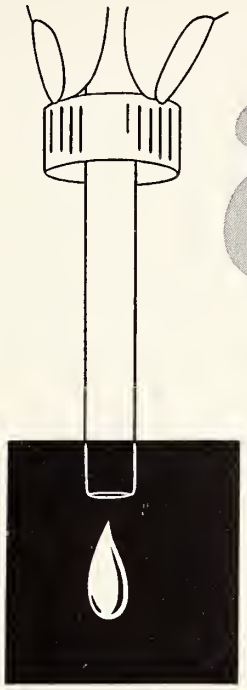
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BOOK REVIEW

PRINCIPLES AND PRACTICE OF SURGERY. By Jacob K. Berman, M.D., associate professor of surgery, Indiana University School of Medicine, Indianapolis. 1378 pages, with 429 illustrations. Price $15.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis, Mo., 1950.

Today it would be futile for one to attempt to write a text which would cover the entire field of surgery. The author of this book has recognized this fact and has written a book, limiting its scope to the correlation of the basic sciences with the principles of surgery. This extensive work is a sequel to the author's "Synopsis of the Principles of Surgery" which has enjoyed remarkable popularity, especially among medical students.

The first fifteen chapters of the book thoroughly consider general physiological and pathological fundamentals as they pertain to the practice of surgery. As the author points out, a textbook of surgery must consider many aspects of almost every branch of basic science and medicine. The first chapter of the book is a short historical review of the practice of surgery, beginning with prehistoric men and concluding with an outline of modern pre- and postoperative care. The chapter on pathology briefly describes the more common laboratory tests, giving their normal values; and also a classification of disease from a pathological standpoint. Gross and microscopic descriptions of the pathology of various diseases are presented in the chapters dealing with the surgical diseases of the various systems. The remainder of the first fifteen chapters thoroughly consider tissue injury both mechanical and bacterial; tissue response to injury; miscellaneous infections; tuberculosis and syphilis.

The part of the book dealing with general tissue reaction to injury is probably the most outstanding; it alone is a complete and up-to-date text for study by the student and for review by the practicing surgeon. Such subjects as: the interchange of body fluids; acid base balance; hemorrhage and shock are considered in a very comprehensive manner. Recent developments in this important field of surgery are discussed, and an exceptional amount of data on normal laboratory findings is presented.

The remainder of the book considers the surgical diseases of the various systems. Each chapter is introduced by the section devoted to the embryology, anatomy, and physiology of the systems under consideration. The gross and microscopic pathology of the various systems and organs is discussed and well illustrated, and the clinical aspects of surgical diseases are thoroughly considered without descriptions of operative technique. Every chapter is concluded with a very extensive bibliography, which greatly adds to the scope of the work.

The author has engaged extensively in research projects, and has also contributed copiously to current medical literature. His thorough knowledge of general surgery is reflected in the pages of this book. Although this work is especially prepared for medical students, all practitioners of surgery will find this volume interesting and extremely valuable.

The book is a magnificent production, and Indiana University Medical School may well take pride in the eminent member of its faculty who is the author of this work.

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Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 19, April 16, May 14.
Surgery of Colon & Rectum, One Week, starting April 9, May 14.
Basic Principles in General Surgery, Two Weeks, starting April 2.
Fractures & Traumatic Surgery, Two Weeks, starting June 18.

GYNECOLOGY—Intensive Course, Two Weeks, starting March 19, April 16.
Vaginal Approach to Pelvic Surgery, One Week, starting April 2, May 7.

OBSTETRICS—Intensive Course, Two Weeks, starting April 2, June 4.

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Electrocardiography & Heart Disease, Two Weeks, starting March 19.

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BOOK REVIEWS

THE PHYSICIAN EXAMINES THE BIBLE. By C. Raimer Smith, M.D., a physician in general practice who has made a hobby of studying the Bible. 394 pages. Price $4.25. The Philosophical Library, Inc., 15 East 40th Street, New York 16, N. Y., 1950.

Doctor Smith is an ardent and thorough student of the Bible and has made the most comprehensive collection of medical references found therein. Any lay or medical student of the history of the healing art will find much instruction and entertainment.

PARKINSON'S DISEASE. By Walter Buchler, London, England. 79 pages. Price $2.00. Walter Buchler, 101 Leeside Crescent, London, N.W. 11, England, 1950.

Every patient with Parkinson's Disease needs the utmost encouragement in his treatment and this little book is a series of comments written by a layman who had this disease. His advice will bring cheer and hope and show the way to a better living even though so afflicted.

DIAGNOSIS AND TREATMENT OF BRAIN TUMORS AND CARE OF THE NEUROSURGICAL PATIENT. By Ernest Sachs, M.D., Research Associate in Psysiology, Yale University, New Haven, 2nd Edition, 552 pages, with 348 illustrations and 10 color plates. Price $15.00. The C. V. Mosby Company, St. Louis, 1949.

This book will be of value to the physician who is interested in the diagnosis and treatment of brain tumors. The book is written in an easily understandable manner and in large print, facilitating easy reading. An excellent chapter discussing surgical anatomy and physiology of the brain serves as a good introduction for such a comprehensive text.

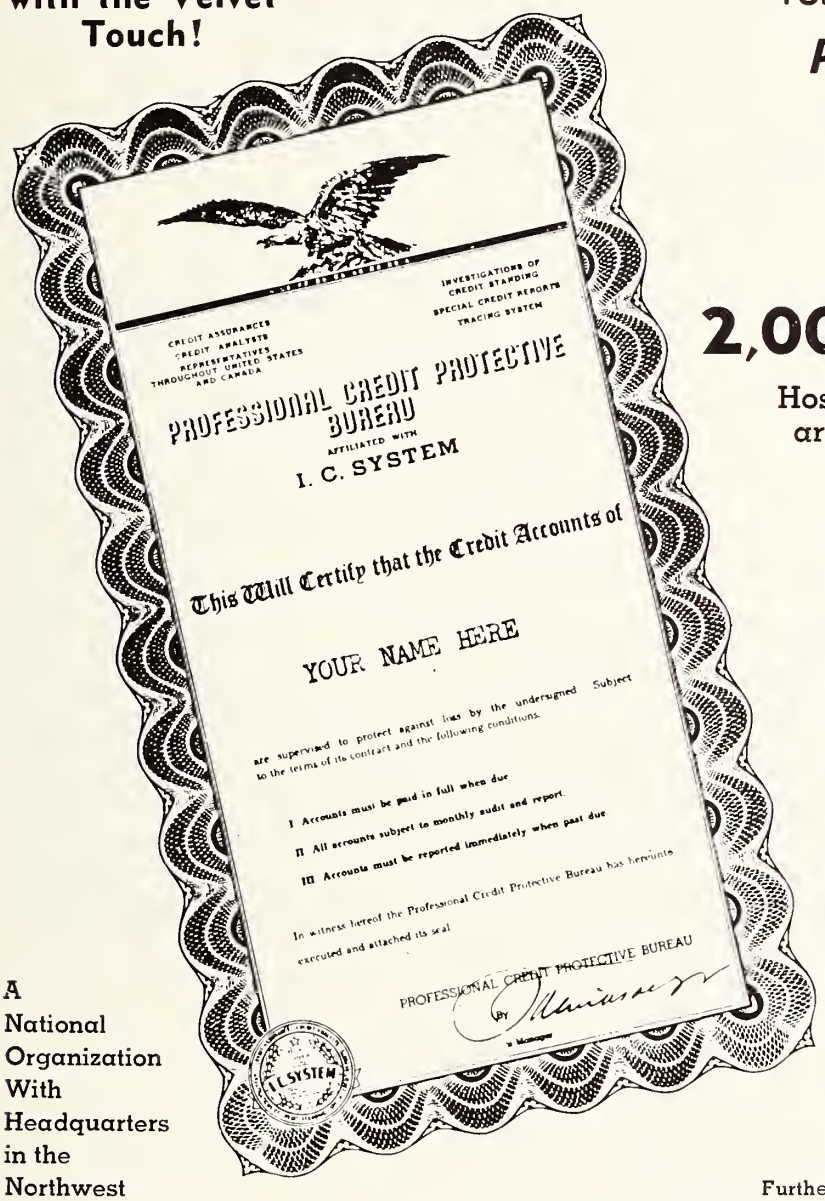
The chapter on Methods of Examination places marked emphasis on the x-ray examination of the skull, 52 excellent illustrations being used to demonstrate changes that occur secondary to tumors of the brain. The author feels that electroencephalography is of interest and at times helpful but, in his experience, does not replace ventriculography in any way. The surgical pathology, signs and symptoms of brain tumors, both general and focal, are discussed in an adequate manner, excellent case histories, photographs and ventriculogram films being used to clarify further the findings in a practical manner. One entire chapter is devoted to the differential diagnosis of brain tumors and other conditions.

Operative techniques and neurosurgical methods are discussed in detail, after which the author discusses single cases of lesions occurring in various areas of the brain and spinal cord, with the idea of discussing the operative procedures and the reasons for employing them. A chapter is also devoted to techniques used in spinal and peripheral nerve operations. The postoperative care of the neurosurgical patient is discussed in a detailed manner, as well. The author feels that the future of neurological surgery is bright and that the possibilities for improvement are almost limitless.

Only a man with the experience of Doctor Sachs could write such a comprehensive text. The value of the hook is greatly enhanced by the use of three hundred forty-eight illustrations and ten color plates. M. F. G.

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Relationship of Stress to Autonomic Lability

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance. [1,2] Such states may involve any one of the organ systems or several at one time. [1,3] The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifesta-tions	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references [3,4,5,6,7], given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. [8,9,10]

1. Ebaugh, F.: Postgrad. Med. *4:* 208, 1948. 2. Wilbur, D.: J.A.M.A. *141:* 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. *42:* 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. *27:* 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. *107:* 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. *58:* 251, 1948.

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BOOK REVIEWS

A PRIMER FOR DIABETIC PATIENTS. By Russell M. Wilder, M.D., professor and chief of the Department of Medicine of the Mayo Foundation, University of Minnesota, senior consultant in the Division of Medicine, Mayo Clinic. 9th edition. 200 pages with 8 figures. Price $2.25. W. B. Saunders Company, Philadelphia, 1950.

A handbook such as this should be in the home of every diabetic. In addition to the understandable instructions given, there is a quiz after each chapter so that the reader can check on his knowledge of the subject.

WHEN MINDS GO WRONG. By John Maurice Grimes, M.D. First edition. 237 pages, with 6 illustrations. Price $5.00. Published and distributed by the author, 5209 S. Harper Ave., Chicago, 1950.

The author of this book is a physician who has been interested in psychiatry for many years. A few years ago he and three other physicians inspected all mental hospitals in the country for the American Medical Association. In the book he states that their report was buried in the Association's files and never made public. He has also been employed as a physician in many public mental institutions throughout the country. The reason for terminating his services in many of these institutions was that he could not tolerate the inadequacy of care given patients, or that he did not vote for the right party.

The book is a poignant attack on the care of mental patients in public institutions. He charges that the principal defects in our present system of state hospitals is that the attendants in these institutions are ignorant, incompetent, irresponsible and frequently brutal; and that state hospital management is controlled by politics.

Statistical material is presented to show that state institutions make very little effort to bring about the recovery or improvement of patients. In 122 state institutions only 10 percent of the patients were discharged as recovered or improved, while in 9 private institutions 58 percent were discharged, able to return to their families and their former occupations.

The author states that the few nurses in these institutions make an honest attempt to give credible service, but there are too few of them employed and that physicians soon recognize that it is futile to do anything but go along with the antiquated asylum system of treating patients by penal methods.

The author suggests a remedy for the situation. The first thing he suggests is to get rid of attendants, that these attendants are merely a low type of guard who floats from one institution to another, and that most of the patients would do much better if unguarded. The service should be performed by doctors, nurses, nurse aids and orderlies. And the next move would be to get these institutions out of politics by a civil service system, or better, have groups of interested private citizens to control mental institutions.

This book, no doubt, contains a vast amount of factual, but not pleasant to hear, material. It should be extremely interesting to psychiatrists, sociologists, politicians, and educational and religious leaders.

D. A. B.

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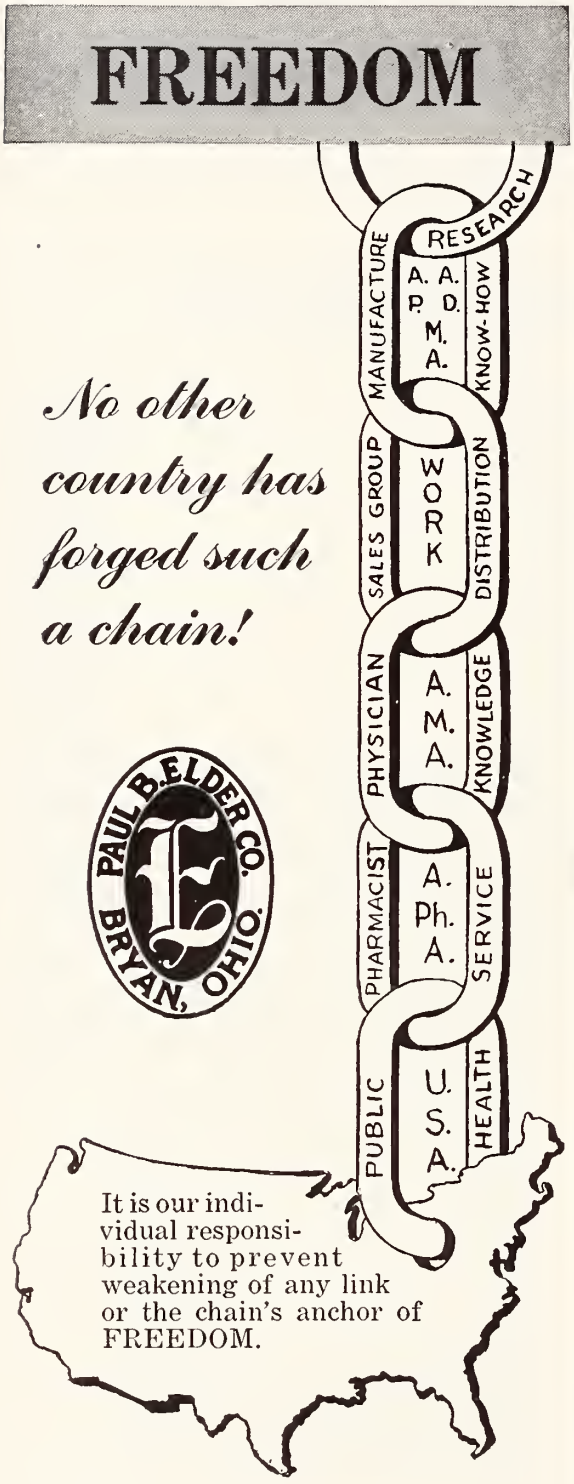
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**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592; Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*



BOOK REVIEW

NATURAL CHILDBIRTH. By Frederick W. Goodrich, Jr., M.D. 176 pages, with 7 illustrations. Price $2.95. Prentice-Hall, Inc., 70 Fifth Ave., New York 11, N. Y., 1950.

The major role which the emotions play in childbirth was recognized many years ago. Many obstetricians have emphasized the fact that it is as important to allay fear and anxiety as to relieve pain. But during the past few years an Englishman, Grantly Dick Read, carried the idea to the extreme, claiming that most women could go through labor without pain relief measures and really derive exquisite pleasure from the process, and that seeing the baby born and hearing its first cry were prerequisites for normal maternal affection. Read attracted a few enthusiastic followers in this country. Many articles have appeared in medical and lay publications on the so-called Read method of delivery. Although an extremist, he did remind the profession of the accepted, but sometimes neglected fact, that the instructed and emotionally adjusted patient does go through labor and delivery more satisfactorily than the patient who is ignorant and fearful of the whole process. Yale University School of Medicine, particularly, has attempted to promote Doctor Read's methods in this country.

Doctor Goodrich has written this manual for expectant parents, stressing to the patient the naturalness of the process of pregnancy and labor and has placed the subject on a sound footing. The anatomy and physiology of the reproductive organs and the development of the fetus are clearly discussed. Exercises are prescribed and shown in diagrams which are supposed to increase the elasticity of the pelvic muscles to such an extent that episiotomy should not routinely be necessary. Other chapters furnish instructions for the patient on relaxation, diet, the importance of visiting the doctor early, and the psychology of easy labor. A desirable feature of the book is that it gives the patient a vision of the whole procedure of starting labor, going to the hospital, the delivery, the postpartum period, and going home.

The book purposely discusses normal pregnancy and labor only, without any mention of complications, obviously to remove all elements of fear. It does accomplish the purpose of attracting attention to a phase of obstetric care which is often neglected. The whole text is prepared in an attractive manner, the material being presented as a story, beginning with conception and ending with the parents at home with the baby. Since it contains no technical verbage, it is extremely readable, even for the average patient. Many illustrations are furnished, some are drawings and others are photographs of Dr. Robert L. Dickinson's models. Since the author does not recommend that women go through labor without analgesia and anesthesia, this manual is sound and acceptable and can be recommended to all patients as a prenatal guide.

D. A. B.

BOOK REVIEWS

PRINCIPALS OF GENERAL PSYCHOPATHOLOGY. By Seigfried Fischer, M.D., clinical instructor in psychiatry, University of California. 327 pages. Price $4.75. Philosophical Library, New York, 1950.

This book is a survey of the most important psychopathological phenomena and their theoretical bases. The book is divided into four parts.

Part I deals with the fundamentals of psychopathological concepts. This part discusses perception, thought, memory, attention, consciousness and unconsciousness, apperception, orientation, emotion, volition, intelligence, phantasy and language, as well as the disturbances associated with these basic phenomena.

Part II discusses dynamic psychology and dynamic psychopathology in great detail, the dynamic principles which operate in neurotic and hysterical disturbances being discussed. The psychopathology which operates in exogenous and endogenous etiologies of mental conditions is also discussed in detail.

In Part III the author discusses the symptom-complexes which are seen in various types of mental abnormalities. He divides his discussion into various areas, discussing the exogenous reaction type, the reactions seen with diffuse damage to the brain, as well as the syndromes found in the various functional syndromes.

Part IV discusses personality, character and temperament as seen in the normal, as well as the changes which are found in neurotic and psychopathic personalities. In this part the author also discusses the relationship between personality and psychosis.

The author has gone into great detail regarding the discussion of the fundamentals of psychopathology and has used frequent references to emphasize further the points of view which he expresses. The book is well written, but in the opinion of the reviewer does not add much to psychopathology as we know it at the present time.

M. F. G.

EYES AND INDUSTRY (formerly Industrial Ophthalmology) Second Edition. By Hedwig S. Kuhn, M.D., Hammond. Foreword by Albert C. Snell, M.D., Rochester, N.Y. 378 pages, with 151 text illustrations, including three color plates. Price $8.50. C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Mo., 1950.

Since injuries to eyes represent a fair percentage of all industrial injuries this book is a must for every industrial surgeon as well as the ophthalmologist and safety engineer.

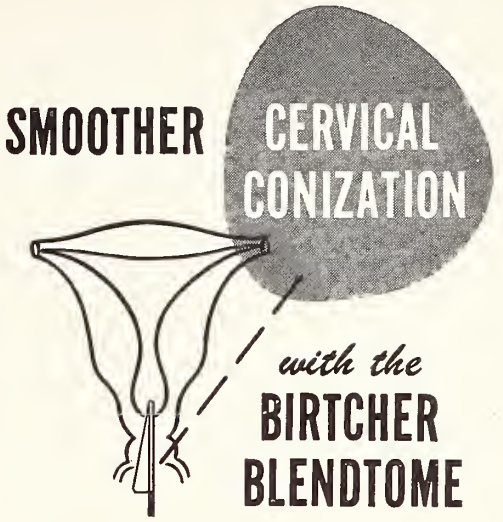
Standing orders for emergency care are carefully outlined and will save many eyes if available to nurses and other on-the-spot personnel.

However, the main theme of the book is prevention, starting with the careful testing and screening of employees. The special testing program is set up in detail. Next the visual skills necesary for common and specific jobs, and problems and aids for the same are discussed. This is of value to any refractionist as the working distance of many occupations are outlined, stressing the importance of fitting glasses for the employee's work.

Of course, safety measures, goggles, illumination, etc., are also taken up.

The chapter on eye injuries by solid objects is written by Albert C. Smith, an authority on this subject.

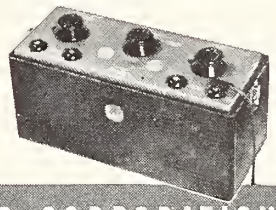
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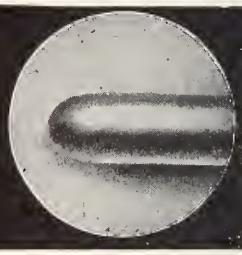
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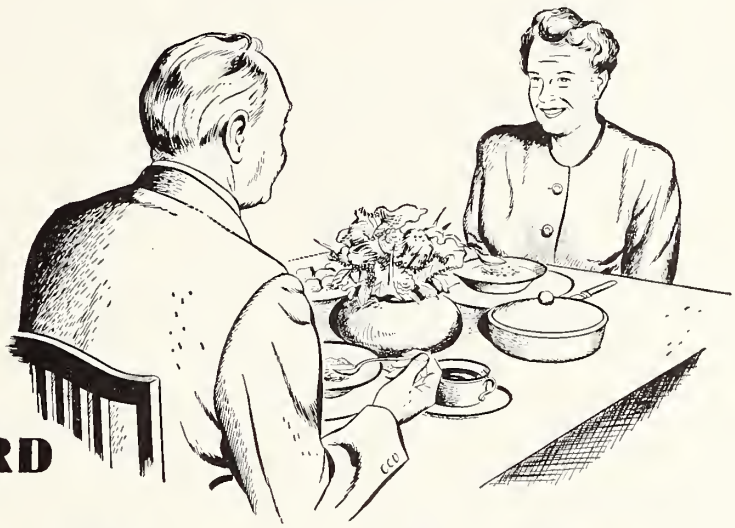
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THE DIFFICULT DIAGNOSIS OF EARLY GASTRIC CANCER

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INDIANAPOLIS

THE enthusiasm of individuals, groups and organizations with both scientific and lay interests in cancer sometimes makes it difficult to maintain sound and sensible thinking about problems of this disease. This is particularly true when one has a consuming interest in cancer, for it is in such a situation that the individual concerned may unwittingly overemphasize it beyond its place in the category of diseases to which man is susceptible. On the one hand, in the total picture of human illnesses, cancer is a significant cause of death, ranking second only to diseases of the cardiovascular system. But, on the other hand, among the problems of health that are brought to the average doctor's attention it occupies a less important place. Yet it causes a tremendous economic loss in money required for the care of patients afflicted with it; it all too frequently destroys individuals who are at the peak of their economic, intellectual and social productivity; and, unfortunately, it is usually discovered in its late and incurable stages, although it is known that when cancer can be detected in its early phases it is a curable disease.

Cancer of the stomach is perhaps the best example of the problem that has been outlined above. It causes more than twenty-five thousand deaths each year in the United States registration area, more than any other carcinoma. Although it may occur in any person from the first decade of life on,[1] the death rate from it reaches its peak in patients sixty-five to seventy-four years of age. The death rates from cancer of the stomach have been surprisingly constant in the fifteen-year period of data available in the United States registration area from 1930 to 1945.[2] Of interest is the fact that there has been a slight decline of deaths in women. It is doubtful if this represents a real decline but is more likely a reflection of better diagnostic methods.

Although such factors as heredity, diet and vitamins, hormones and bacteriological agents have at various times been considered potential predisposing or association factors in this disease, the etiology of gastric cancer, like that of most types of cancer in the human, is not known. From time to time reports have appeared indicating that there are racial and other differences in the incidence of gastric cancer, and, although knowledge of different susceptibilities of various strains of inbred laboratory animals to a variety of cancers would lead us to believe that racial differences might exist in man, the statistical significance of data of this sort is questionable. For example, it has been reported that there is a higher incidence of cancer of the stomach in the northern United States than in the southern.[3] Such data might suggest that climatic or geographic variation held a key to the question. Yet, on the other hand, further studies reveal that the same group of southern states that reports a low incidence of gastric cancer also reports a low ratio of physicians to the population as a whole, thus intimating that the true explanation is in differences in availability of diagnostic facilities.

Statistics on the importance of the influence of

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heredity and genetics in its origin are stimulating, but as yet inconclusive. As in other forms of cancer, histories of exceptional families with a high incidence of gastric cancer have frequently been reported. The most famous record is probably that of the family of Napoleon where it is stated Napoleon, his father, grandfather, all three sisters and one of four brothers died of gastric cancer. Strangely enough, there has been no record of cancer having been found in descendants of this family. Although reports of families of this kind make interesting reading, the quantity of data on them is insufficient to conclude that heredity is a factor.

Evidence accumulated over the course of years that gastric cancer is common in man but rare in animals, makes the thought that the cause lies in something associated with the diet of man intriguing. Yet the proof of this evidence has not appeared. A significant clinical study of this phase was the comparison of the diet in groups of people in Holland with the diet of similar groups in England, where the incidence of gastric cancer is only about one-half that in Holland.[4] The Hollanders consumed a diet consisting of large amounts of bread, cheese and vegetables, and a smaller amount of meat, and also ate food at a higher temperature, as well as larger amounts of spices and various spirits. Experimentally there is lack of agreement among investigators concerning the production of gastric cancer in animals by dietary means alone. One of the most controversial approaches has been that of Roffo,[5] who stated that adenocarcinomas were produced in the stomachs of rats fed a diet containing heated fats. Some investigators, however, believe that the lesions described by Roffo did not meet accepted criteria for malignancy and others were unable to repeat his investigations.

The same type of broad exploration with inconclusive results has occurred in hormone and bacteriological studies of gastric cancer.

Such investigative approaches to the problem are of interest but of little practical use to the practitioner of medicine when he is faced with the problem of suspected gastric malignancy in a human patient. Indigestion and dyspepsia are common human complaints. Rivers[6] has stated that of the twelve most common causes of dyspepsia, carcinoma of the stomach ranks no higher than tenth. This realization places a doctor in a difficult position when a patient in an age group where gastric cancer is common comes to him complaining of vague, indefinite abdominal difficulty. Shall the physician immediately start him through a series of diagnostic tests, including a gastrointestinal series that may entail an expenditure on the patient's part of a hundred or more dollars, realizing that none of the tests may be positive; or shall he treat the patient symptomatically, thus losing an opportunity to make a diagnosis of early cancer of the stomach, or in other words, of curable cancer? The question is not easily answered. No routine manner of approach to it can be established that will be equally applicable to all such patients. Not every patient with indigestion has gastric cancer, of course. Yet if the diagnosis of early gastric cancer is to be made with consistency the diagnosis must be considered in every middle-aged patient who complains of indigestion. Other difficulties are that some carcinomas of the stomach may not cause any symptoms at all until they are in an advanced, incurable stage; and that carcinoma of the stomach that is truly early, and, therefore, potentially curable, may cause no symptoms whatsoever. On the face of it, the knowledge of such facts may be utterly discouraging, yet certain other facts about the disease give us hope that alert application of our available diagnostic facilities will help us discover more early and curable gastric cancer.

Pernicious anemia seems to have a definite relationship to gastric carcinoma. Rigler and Kaplan[7] have demonstrated that gastric cancer is twenty times as common in patients with pernicious anemia than it is in the population as a whole. Other corroborative evidence is that more patients with gastric cancer have pernicious anemia than would normally be expected; a similar high incidence of pernicious anemia is not found when cases of cancer of the large intestine are surveyed for pernicious anemia; and patients with pernicious anemia and a tumor have most of their tumors in the stomach. If the thesis is true that there is a definite association between pernicious anemia and gastric carcinoma, and present evidence seems to indicate that it is, then this knowledge can be used in a practicable manner in the control of gastric cancer. All patients with pernicious anemia should be watched carefully for the onset of either gastric cancer or gastric polyps with periodic gastrointestinal x-ray examinations. Such observations should lead to the discovery of more early gastric cancer in such a selected group than would be expected from a study of an equal number of patients in the population at large. For example, the studies of St. John and his associates[8] revealed only three gastric cancers in a series of x-ray examinations of over twenty-four hundred well people, whereas those of Rigler and Kaplan on two hundred and eleven patients with pernicious anemia revealed seventeen cases of gastric cancer and fifteen of other benign tumors.

Gastric polyps are also definitely associated with gastric cancer, and there is wide general agreement that they are precancerous lesions. The problem of their management is small compared to the total problem of the management of gastric pathology, yet it is estimated that between 12 and 50 percent of gastric polyps become malignant. They should be treated surgically by a subtotal or total gastrectomy, depending upon the extent of polypoid disease, rather than by local excision of the polypoid growth.

Gastric ulcer also seems to have a definite relationship to gastric cancer, although the vast amount of literature on ulcer has only a small portion of it devoted to the problem of ulcer and cancer. The majority of authors who have expressed their thoughts on this association believe that 10 to 20 percent of gastric cancers arise in gastric ulcers.[9] The location of the ulcer is an index to its probable malignancy. Allen[10] states that all ulcers on the greater curvature of the stomach are malignant ulcers; that 65 percent of those in the prepyloric region are malignant and 10 percent of those on the lesser curvature. This is a field where vigorous and bold surgical management may aid in decreasing the mortality from this disease. The writer believes that all ulcers on the greater curvature of the stomach and in the cardia of the stomach should be treated with surgery, as well as all ulcers in the prepyloric region and on the lesser curvature, if they do not heal in a reasonable period of time with sound medical management. Gastroenterostomy for gastric ulcer should never be done.

Atrophic gastritis associated with gastric cancer has been one of the most frequently discussed observations concerning the origin of this disease.[9] Although some investigators consider that as high as 90 percent of gastric cancers arise on a basis of gastritis, others in recent years have concluded that the relationship between chronic gastritis and cancer is incidental and that direct proof of a sequential relationship is lacking. Atrophic gastritis is a common condition with advancing age and is frequently seen in association with many diseases other than gastric carcinoma. On the other hand, from the clinical point of view, the great bulk of gastric cancers are associated with gastritis and, therefore, the association must be viewed with some degree of suspicion.

Achlorhydria is associated with gastric cancer in 60 percent of the cases and subnormal acid in another 20 percent.[11] The connection is probably indirect, yet only 20 to 25 percent of the general population in similar age groups, but without gastric cancer, have achlorhydria. The association therefore seems to be real, although it does not follow that the one precedes the other, nor has it been shown that the one is responsible for the other.

It is not the purpose of this discussion to review the well-known signs of gastric cancer, signs that are usually indicative of late disease rather than of early, such as emaciation, nausea, vomiting and a palpable epigastric mass, nor the signs indicative of incurable disease, such as enlarged supraclavicular lymph nodes and a rectal shelf, but rather to discuss ways and means by which early gastric cancer may be detected. The persistent presence of occult blood in the stool, as indicated by the guaiac test after a three-day meat-free diet, is a reliable test that can be done in any doctor's office. A patient who complains of dyspepsia, who has occult blood in the stool and who is in the cancer age group should be suspect until proven otherwise. Furthermore, a gastric analysis and blood counts can be done before the patient is asked to go to the expense of the more complicated and yet more definitive diagnostic procedures such as a gastrointestinal series. This is perhaps our most reliable diagnostic aid in discovering gastric carcinoma and will alone assist us in arriving at a positive diagnosis of early gastric cancer in 80 to 90 percent of the patients. There are times when gastroscopy is of help in an individual who has an ulcer that is suspiciously malignant to the clinician and the radiologist. It is a reliable procedure in the hands of trained and able people and will give a positive diagnosis in approximately 80 percent of patients examined. The cytological examination of gastric washings is a relatively new diagnostic procedure. The smear technique is probably not as reliable as that described by Richardson,[12] who recommends imbedding the sediment of the gastric fluid in a manner comparable to the fixation, imbedding and staining methods used on other pathological material.

The treatment of gastric carcinoma is, of course, gastrectomy. Lahey[13] and others have suggested the operation of total gastrectomy for carcinoma of the stomach. Yet, it does not seem as imperative to do a total removal of the stomach when cancer exists as it does to do a wide and thorough removal of the lymph node-bearing areas in the gastrocolic omentum, the gastrohepatic omentum and the greater omentum. If, in the wide removal of these structures the blood supply of the stomach is compromised, a total gastrectomy must, of course, be accomplished. Otherwise it does not seem necessary. The patient who dies from carcinoma after a gastrectomy does not die as a rule from carcinoma recurrent in the stomach itself, but carcinoma that has metastasized to lymph nodes or to other organs of the body.

If there are no signs of distant metastases in the lungs, supraclavicular lymph nodes, pelvic peritoneum, or other regions, every effort should be made to operate on every patient with suspected gastric cancer. On the one hand, it is admitted that the overall picture of gastric cancer is dismal, since only 6 to 8 percent of every hundred patients will survive five years. But, on the other hand, it has been demonstrated[14] that 33 percent of all patients who survive surgery will live five years, and 42.8 percent of all who survive surgery and who do not have lymph node metastases at the time of operation.[15] These data indicate that if a gastric resection can be done on gastric cancer that is truly early, the patient has an excellent chance for a long term survival period free of disease.

SUMMARY

A reasonable plan of management of a patient with either dyspepsia alone, or with suspected gastric cancer is as follows: a stool examination for occult blood after a three-day period on a meat-free diet should be done, as well as a gastric analysis and a complete blood count. If either the stool is positive for blood or the gastric acidity is abnormally low, then a complete gastrointestinal series should be requested. Gastroscopy and a cytological examination of the gastric contents for malignant cells both can be employed where the diagnostic problem is complicated.

Every patient with a suspected gastric carcinoma should be operated upon unless distant metastases are proven; and every carcinoma found at operation should be resected if it is technically possible to do so.

Gastric polyps are premalignant lesions. Gastric carcinoma is so frequently associated with pernicious anemia that it may also be considered to be premalignant.

The prognosis for a patient who has had a successful gastrectomy for early carcinoma is excellent.

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PNEUMONITIS COMPLICATING CANCER OF THE LUNG

ROBERT B. SANDERSON, M.D., AND JAMES M. WILSON, M.D.

SOUTH BEND

THE SIGNIFICANCE of malignant disease in the chest increases continuously. There is evidence of gradual increase from a relatively rare condition to one which claims the position of being one of the most frequent sites of cancers. Graham[1] advises that it is probably "the most common visceral cancer" in man and adds that it is "curable by total pneumonectomy if the surgeon gets the patient in time."

Beeler and Irey[2] report 7 percent of 845 autopsied cases of malignant disease were carcinoma of the lung. The disease may occur at any age. Clark, Temple, and Allen[3] observe that "Bronchogenic carcinoma can arise in any part of the lung at any age."

Even though the disease is increasing rapidly and when not treated early is inevitably fatal, it is disconcerting to know that it is often advanced when diagnosed. This is not always because the patient is slow to seek medical advice, nor is it due to the lack of diagnostic facilities, but rather to the peculiar benign symptoms with which the tumor is almost always ushered into the attention of the patient and the physician. The universal symptom of cough and the frequency of respiratory infections almost always confuse the early diagnosis of this fatal disease.

Leach and Robbins[1] advise that "the basic cause for the lack of improvement (in the cancer mortality) is the prolonged delay between the time when the patient has first symptoms and the time when definitive treatment begins."

There was a time when most of the errors in pulmonary diagnosis concerned tuberculosis. Many

patients with mild respiratory symptoms consulted physicians who treated them for what seemed to be innocent bronchitis or lung infections, only to discover months later that progressive tuberculosis had advanced, much to the danger of the patient and the embarrassment of the physician. In many cases the symptoms were ignored entirely and the patient did not bother to consult the physician until the disease was advanced.

A more general interest in tuberculosis, and the ease of sputum examinations and the use of x-ray as a routine part of the chest examinations, have corrected many of these mistakes. Any inflammatory process revealed in the x-ray of the lungs suggests the possibility of tuberculosis, and the x-ray appearance is frequently rather characteristic.

Now we are confronted with an even more hazardous mistake in pulmonary diagnosis, the error of overlooking malignant disease. The purpose of this paper is to call attention to the frequency with which malignant disease in the lungs is accompanied by the ordinary symptoms, signs, and the frequent x-ray appearances of innocent pulmonary infections, a situation which invariably confuses the diagnosis and often leads to fatal delays.

Most malignancies in the chest are far advanced when diagnosed, and only about 30 percent are considered operable when they are seen by the surgeons. Since surgery is our only satisfactory means of treatment, and since the diagnosis is often confused by what appears to be an ordinary medical problem, it seems important to emphasize the frequency with which serious disease is accompanied by what appear to be innocent symptoms and signs.

It is not to be presumed that every cancer of the lung can be diagnosed early, but if we are to cure more cases then more *must* be diagnosed early. It is imperative that we suspect cancer even though we may be dealing with infections, and if the "pneumonitis or influenza" does not clear up in three or four weeks we should use all of the means at our disposal, including sputum smears for malignant cells, bronchoscopy, and biopsy, to prove the presence or absence of malignant disease.

The following clinical reports are submitted for illustration:

L. Y., age 40

This man was admitted to the hospital on 1-30-49, giving a history of cough and fever extending over a period of six weeks, and of hoarseness extending over a period of about three months. The man thought he had *caught cold* about six weeks before admission and he developed a *fever* which went to 105, after which he seemed to improve. The sputum examination for malignant cells and acid-fast bacilli were negative. X-ray revealed evidence of tumor in the mediastinum and, in spite of the negative findings, biopsy of the tumor revealed an undifferentiated carcinoma and it was considered so far advanced that surgical treatment could not be successful.

T. T., age 45

This man was admitted to the hospital on 10-28-48 complaining of a chronic cough and daily fever. He had previously been hospitalized as early as May and had been treated for what appeared to be pneumonia. Later he developed evidence of lung abcess, and bronchoscopy and sputum examination revealed no evidence of malignancy even though the patient continued to do badly and serial x-ray films revealed evidences of a tumor developing in the abcess. The diagnosis suddenly became clear; the lung was removed surgically, showing a bronchogenic carcinoma, and the patient died a few months later.

J. M., age 49

This man was admitted to the hospital on 12-17-49 complaining of fever and cough, with a diagnosis of pneumonia and empyema. The empyema was drained and he was discharged on 12-21-49. Symptoms recurred and he was admitted on 1-10-50, the empyema was drained by the closed method and he was again discharged on 2-1-50. The situation seemed to improve for awhile but he returned to the hospital on 3-16-50, at which time it was necessary to open the chest and drain the empyema. He improved and again left the hospital on 3-30-50. He returned on 4-3-50 in anticipation of having an operation to obliterate the empyema pocket, but before this was completed a biopsy of the pleura was done, which showed a diagnosis of fibrosarcoma. The patient progressed to an unfavorable termination and died on 7-17-50.

C. D., age 42

He was admitted on 6-22-50 complaining of having caught cold during the previous March and complained of some pleurisy in May. His present complaint was cough and progressive weakness, and the sputum smears were negative for malignant cells; however, a button preparation of the sputum revealed malignant cells and exploration revealed the carcinoma too far advanced for operation.

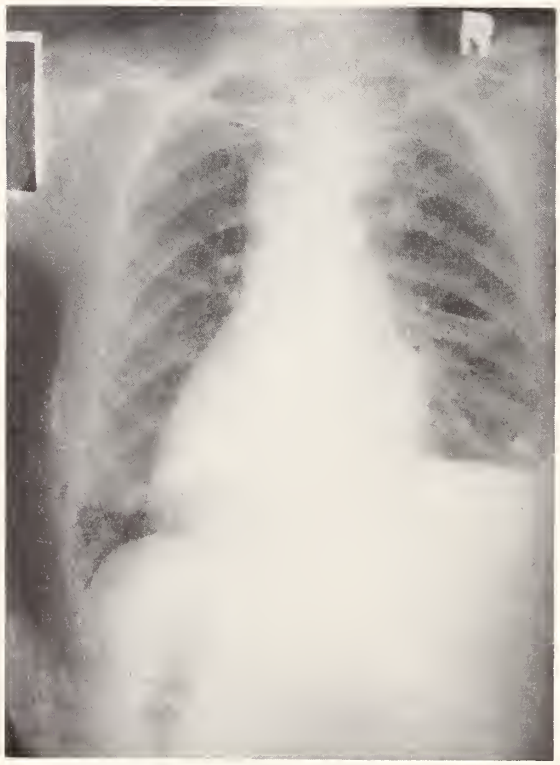
H. H., age 56

This lady was admitted on 6-25-50 giving a history of having been treated for asthma for the past 15 years, during which time she had a persistent cough. Many x-rays were negative. The x-ray at this time revealed a mass in the left mid-lung, but the sputum smears were negative for malignant cells. Biopsy at operation revealed a bronchogenic carcinoma (oat cell) which was considered too far advanced for operation.

C. M., age 63

This man was admitted to the hospital on 2-4-49 giving a history of having had a cough over a period of five or six months. During the past three months there had been some hemoptysis and in the previous December he caught "cold" and was hospitalized with a diagnosis of pneumonia.

Figure 1.



M. B. Minimal changes in Right Lung on 6-6-50.

The infection improved under treatment and an incidental finding in the course of sputum examinations were malignant cells. This led to a diagnosis of cancer of the lung complicated by the pneumonia for which the man was being treated. He was admitted for surgical treatment. The only important previous hospital record had been three years ago when he was hospitalized for 13 months because of fibroid tuberculosis, which was apparently arrested at the time of the present admission. X-ray revealed evidence of an increase in density in the right lower lobe and surgical treatment was decided upon, there being no evidence of metastasis. The right, middle, and lower lobes were removed surgically. The diagnosis was bronchogenic squamous cell carcinoma and the man was discharged on 2-22-49, after being in the hospital for 18 days. He has remained well since, 18 months after the surgical removal of the cancer.

M. B., age 55

The patient had no significant previous illnesses but consulted her physician in May 1950, at a time when it was thought she had influenza, with some discomfort in the right shoulder. The symptoms and signs were extremely mild and the patient improved after treatment. A small thyroid gland was noted but no particular attention was paid to this detail.

She was admitted to the hospital early in June because of a fast pulse and the B. M. R. was noted to be 36. At this time examination of the chest revealed a very slight linear atelectasis in the middle lobe on the right, with slight pleural thickening in the sulcus. The patient appeared to improve and was sent home on a medical management of mild hyperthyroidism. At the time she was hospitalized there was a very slight cough. She was readmitted to the hospital about two months later, at which time she had a massive atelectasis of the right lung with cancer cells in the sputum and the pleural fluid. Considering the late diagnosis, the physician can have only the unpleasant satisfaction of knowing that the tumor had already involved the pleura when she was first seen in the hospital. (See Figure 1 and Figure 2.)

M. L., age 31

This patient was admitted to the hospital on 3-8-48 giving a history of having had discomfort and dull ache in the left chest over a period of several weeks. She had an occasional nonproductive cough. A previous diagnosis of pneumonia complicated by an emphysema had been made. There was physical and x-ray evidence of fluid in the left chest and the temperature was 103. Aspiration of the chest revealed clear fluid which became bloody as the aspiration proceeded. Culture of the fluid revealed cocci but the fluid was not examined for malignant cells. A second attempt to aspirate was unsuccessful and since malignancy was suspected the pleura was opened and biopsy revealed a hemangioendothelial sarcoma of the pleura. The patient continued an unfavorable course and died in September 1949. Another case of malignancy of the lung in which the earliest manifestation suggested pneumonia.

Figure 2.



M. B. Marked atalectasis in Right Lung on 8-28-50. Advanced cancer.

G. R., age 53

This man was first seen on 5-17-50, giving a history of having a cough for approximately a year and having expectorated blood on numerous occasions for the past four months; and there had been an increase in shortness of breath during the past several months, as well as a loss of 20 pounds of weight. The history indicated that he had consulted his physician and had been treated for influenza on two occasions, and that the condition had been previously diagnosed *pulmonary infection.* Examination revealed a marked atelectasis at the base on the left, cancer was suspected, and the patient was hospitalized. The diagnosis of malignancy was confirmed and he was prepared for surgery on June 12. At the time of operation the disease was found to be too far advanced for successful treatment.

N. B., age 34

Had "pneumonia" in January, 1950. In July examination revealed a persistently thick pleura on the left and the patient was getting weaker daily. The cough was intractable and had been particularly aggravating since October 1949. Cancer of the bronchus was suspected and bronchoscopy revealed a large tumor from which a biopsy was removed, and the diagnosis of squamous cell carcinoma of the bronchus was confirmed. The disease was inoperable.

Here, in the case of a 34 year old, healthy man, the diagnosis of "pneumonia" confused the real malignancy until it was so far advanced that no treatment could be offered.

R. F., age 21

This man was first seen on 2-8-49 at which time he gave a history of having had some pulmonary distress during the past few weeks. The difficulty had at first been considered an *infection in the lung* for which he had been treated. An x-ray had been taken and fluid suspected in the chest. At this stage he was referred for consultation. Even though the sputum was negative for malignant cells the patient was immediately referred for bronchoscopy since malignancy was suspected. The disease was entirely unilateral and it was suspected that the man had a primary carcinoma of the bronchus. Two physicians and one intern found no other significant abnormalities and the patient reported no other difficulties. Bronchoscopy confirmed the presence of the suspected bronchial tumor and biopsy revealed evidence of an undifferentiated neoplasm, and the pathologist suggested that it might be metastatic from the testicle. On the same day the pleural fluid was reported as being positive for malignant cells. After this information was available the patient was reexamined and a small tumor of the testicle was found. This tumor had not been noticed by the patient and had been overlooked by three examining physicians. The pulmonary disease was too far advanced for any treatment and the patient died a few months later.

J. U., age 40

This man was first seen when he was coughing up blood. He had previously had an x-ray of the chest six weeks before, at which time a diagnosis of *tuberculosis* was suggested. Two sputum examinations had been made by the laboratory but the reports were uncertain. At the time of the first examination the clinician said "We suspect tuberculosis but it could be cancer."

A review of the x-rays, the persistently negative sputum examinations for tuberculosis, and the peculiar appearance of the x-ray, made the suspicion of tumor so strong that he was referred for surgical consultation. The diagnosis of cancer of the lung was confirmed and the lung was completely removed surgically. The operation was completed thirty-one days after the patient was first seen. The postoperative diagnosis was bronchogenic cancer and it was felt that the entire tumor had been removed and there was no evidence of metastasis in the regional lymph nodes.

The postoperative course was satisfactory and the man appeared to improve. But within a year there was evidence of metastasis in the other lung and the patient progressed to an unfavorable termination as the malignancy advanced into his remaining lung.

In reviewing the patient's situation before operation the surgeon was impressed with the probable significance of infection. In consideration of the confusing picture he wrote as follows: "I believe that most of the findings that we see in the films are, however, the result of *pneumonitis* because of bronchial obstruction by a tumor."

M. M., age 40

The details of the previous history and the x-ray of this patient were reviewed at the request of the referring physician on 8-4-50. The man had reported to his physician about one month previously complaining of slight fever, slight cough, malaise, and a self-made diagnosis of *influenza.* The physician prescribed and the patient reported a few days later that he was improved, but since he continued to have a slight fever it was suspected that the man might have *"virus infection"* and aureomycin was prescribed. The man reported a few days later that he was markedly improved, the symptoms had disappeared, and he was fever-free. At this time both the physician and the patient were inclined to the opinion that the "infection" was under control. The man continued on a vacation trip and in an effort to be insured against a recurrence of the symptoms he supplied himself with a generous amount of aureomycin to be taken on the way. The symptoms of infection did recur during the vacation trip but this time aureomycin did not help. When he reported to his physician his general situation was extremely unsatisfactory and he was referred for x-ray of the chest. This examination revealed extensive bilateral multiple metastasis in both lungs, considered so far advanced that no treatment could

be helpful. No additional effort was made to find the source of the tumor.

O. P., age 40

This man was first seen in June 1943, at which time he had what appeared to be an acute pneumonitis in the upper portion of the left lung. After treatment the man improved clinically even though the x-ray did not show significant improvement. The principal concern of the consultant at the time was the possibility of overlooking tuberculosis.

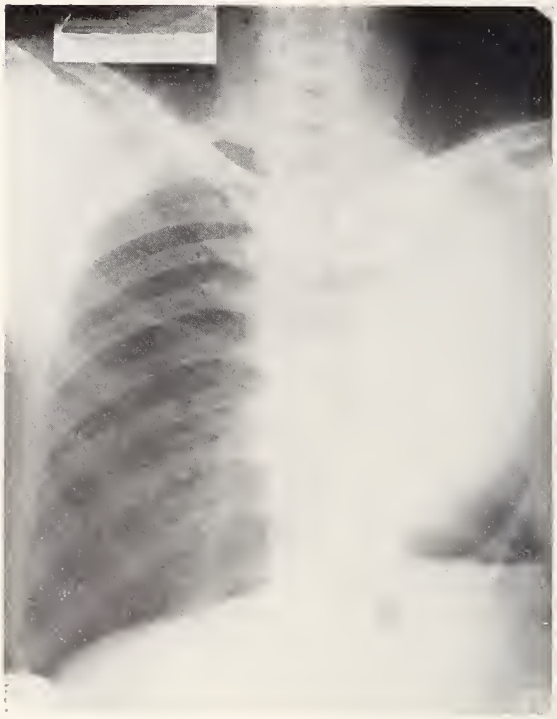
Since the situation did not improve he was referred to a thoracic surgeon for more careful study, and bronchoscopic examination failed to reveal the true nature of the disease. In spite of the impossibility of obtaining confirming evidence of tumor, surgical treatment was decided upon and the lung was removed. The lesion was a grade three squamous cell carcinoma arising in the left upper lobe bronchus and causing "considerable pneumonitis" in the obstructed portion of the upper lobe. The pneumonectomy was completed on 8-16-43 and the patient has remained well since. If the possibility of tumor had been overlooked or if the clinical improvement after he was first treated had been considered a definite sign of improvement the tumor might have been overlooked entirely. (Figure 3.)

The man is well seven years after pneumonectomy for cancer of the lung.

D. M., age 40

This man was admitted to the hospital on June 30, 1943, giving a history of having "caught cold" about ten days previously. These symptoms had been accompanied by "congestion in the chest" and some shortness of breath. He was inclined to consider that he had some distress in his right shoulder. On examination it was discovered that he had some fluid in his chest and aspiration revealed it to be bloody. It was immediately examined for cancer cells and it was reported to be suspicious, and a diagnosis of cancer of the lung with pleural effusion was made. The condition was considered inoperable and he progressed unfavorably until March 1944, at which time autopsy confirmed a diagnosis of primary cancer of the lung.

Figure 3.



O. P. Healthy 7 years after pneumonectomy for bronchial cancer.

SUMMARY

Cancers of the lung, including the bronchi and pleura, are among the most common malignancies. Early diagnosis is essential for satisfactory treatment because surgical removal of the cancer before metastasis is the only satisfactory method of treatment. The early diagnosis of malignancy of the lung is almost always confused by signs and symptoms of mild respiratory infections, including both cough and fever. This is due to localized pneumonia causing fever, a situation which almost always improves with antibiotic treatment. This improvement fools the patient and the physician and frequently results in a long delay in diagnosis.

Attention is called to the importance of careful follow-up examinations on all respiratory infections, and sputum examinations for malignant cells should be routine in such cases. If the symptoms and signs and x-ray findings of pneumonia, pneumonitis, unexplained pleurisy, lung abscesses and localized atelectasis are not cleared up in three or four weeks, cancer should be looked for. Symptomatic improvement after treatment should not lull the doctor into overlooking the possibility of cancer. Sputum examinations for malignant cells should be repeated several times in doubtful cases and bronchoscopy should be used to investigate the larger bronchi. If the condition suggests tumor and no pathological material can be obtained to prove the diagnosis, biopsy should be made of the questionable lesion. Only by thinking of cancer early can it be diagnosed early.

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CARCINOMA OF THE BREAST

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CANCER of the breast has been studied exhaustively and the literature is replete with series of cases pointing toward one variation of treatment or another. The gains made by these studies have been minor and the overall picture remains much as it has been for the last few decades.

A great deal has been said about the importance of early diagnosis. Realization of this point by both doctor and patient has lowered the mortality in this disease more than any other single factor. Notwithstanding this, it is discouraging to find so large a proportion of patients still coming to the hospital with advanced lesions. Well over half of the patients coming to operation already have axillary involvement.[1, 2, 3, 4, 5]

It is hoped that the recent intensive lay propaganda on this point will bear fruit. This, however, will require some years to evaluate.

Lay articles advising women to see the doctor about any lump in the breast have posed a real problem for the medical profession, a problem which cannot be completely solved. All those working in tumor clinics are quite familiar with the flood of breast cases reporting after the appearance of an article on breast cancer in any of the large circulation magazines. Most of these patients have cystic disease of the breast, some are neurotics, an occasional one has cancer.

It is the patients with cystic disease or adenosis who present the unsolved problem. To illustrate the point, it might be well to cite two such cases recently seen in the tumor clinic. Both had quite characteristic benign breast changes on which a course of watchful waiting would ordinarily be followed. However, both of these patients and their family physicians insisted that a biopsy be done. Consent was given with considerable reluctance toward those who would question our diagnostic ability. This feeling changed to complete embarrassment on finding carcinomatous changes embedded in the expected fibrocystic changes. (Figure 1.) Certainly in the past we must have made similar mistakes, declaring a breast to be benign when a malignant focus lay masked beneath a benign lesion. There is also the ever-present possibility of choosing the wrong site from which biopsy is to be taken. Recently, attention has been called to metastatic breast carcinoma without clinical breast findings.[6, 7]

What is the answer? Certainly it is not to biopsy or amputate every lumpy breast. On the other hand, some of these cases will progress beyond a possible cure by the time they are suggestive of cancer. Possibly, for the present, a middle course should be followed using an excisional biopsy on many more women than has formerly been done. By so doing, it is hoped that a few more early cases may be added to those now seen.

Thought along this same vein brings to mind another situation which has been confusing and embarrassing to many. The public has been completely sold and accepts the dictum that "early cancer is curable." This is as it should be. A change is not suggested even though the statement is only a half truth. "Early" to the patient means at the onset of signs or symptoms, whereas in reality the tumor may be in a late stage by the time the individual has any reason for suspicion. The lesion may be incurable before any abnorm-

Figure 1.



Biopsy of breast which presented a clinical picture of chronic cystic mastitis. As shown, there was ample evidence of cystic mastitis, but an infiltration of cancer cells is also present.

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ality can be found by the clinician. The patient is led to believe we are capable of curing that which is quite beyond our reach. Of course, this is less true of the breast than of other regions, such as carcinoma of the stomach. Nevertheless we still fail many times in "early" cancer of the breast and break faith with those who have been led to believe a cure is probable.

Further discussion is best integrated with a summary of the cases studied. These consist of 255 consecutive breast cancer patients admitted to the Indianapolis General Hospital and the University Hospitals from 1930 to 1938. The follow-up was in the hospital clinic except where this was impossible because of out-of-town residence. Here contact was made with the patient's local doctor or family. A satisfactory follow-up was obtained on 94 percent.

The series is admittedly small and the results are in no way unusual. They are average, being neither as good nor as poor as the results of other institutions. They emphasize points made in other reports and are in conflict with a few recent reports.

First of all, it seemed of interest to know what happened to the average case of breast cancer entering our hospitals. This may be seen graphically in Figure 2. Some 19 percent of all patients were found on admission to have advanced lesions which were considered inoperable. Two patients (.8 percent) in the entire study refused any operation. The inoperable patients were treated with x-ray and a few palliative simple mastectomies were done to remove the local fungating mass. Half of these patients were dead at one year and all were dead at three years.

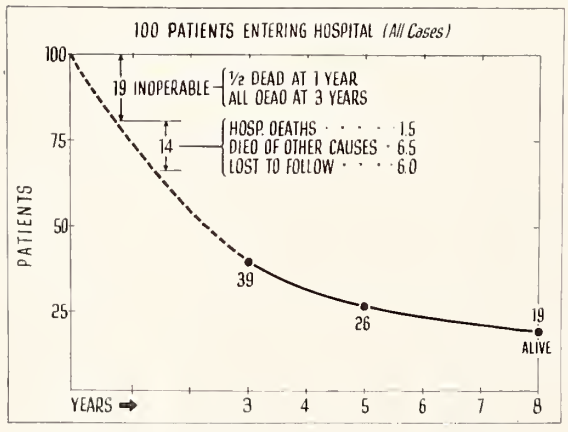
The remaining 80 percent were considered candidates for radical mastectomy. This was carried out in practically every instance but there were a few so-called "modified mastectomies" in which one or both pectorals were left intact after removal of the breast and axillary contents. There was a 1.5 percent hospital mortality following surgery.

This left 78.5 percent of the original admissions discharged from the hospital with a mastectomy and hope of cure. These decreased to 39 percent by the end of three years, and only 26.3 percent were known to be alive at the end of five years. With the passing of three more years only 19 percent of the original hospital admissions were known to be alive. It should be noted that 7 percent of our cases are known to have died of causes other than cancer, and as previously noted 6 percent were lost to follow-up.

When presented in this fashion, on the basis of all patients applying for treatment, the outlook is indeed gloomy. When, however, it is placed on the usual basis of postoperative results a considerably brighter outlook is apparent. This is particularly true when the operative results are further broken down.

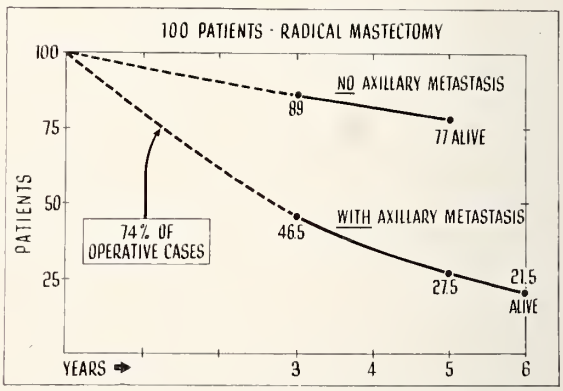
In Figure 3 the postoperative results are shown on all cases. These have been divided into patients with axillary metastasis and those without. It will be noted that 77 percent of patients without axillary extension were known to be alive at five years. In those having axillary involvement by pathologic study, but 27.5 percent survived the five years. This often repeated graph and the moral which it preaches cannot be too often presented. Whether it is this series or any other, the picture is all the same. The discouraging feature is the difficulty in getting more patients in the upper 77 percent curve rather than with the large majority in the lower curve. As noted, only 26 percent of our

Figure 2.



For clarity, the percent figures have been transposed to indicate results for 100 breast cancer patients admitted to the hospital. As shown, about one-fifth are grossly advanced and inoperable. Only one in four of those original admissions will be alive in five years.

Figure 3.



Less gloomy record is shown for those patients coming to operation. It is seen that where there has been no extension beyond the breast (upper curve) 77 out of 100 patients are known alive at five years. This is a record of which to be proud, but as also indicated, only one-fourth of the operated cases fell into this favorable group. Three-fourths of the operative cases had already extended to the axilla with the unfavorable results indicated.

operative cases were free from axillary metastasis. Other institutions[1, 3] have given a considerably better proportion of axillae free of metastasis.

It is quite obvious that we can never obtain 100 percent or even 90 percent of operative cases in which the disease is confined to the breast. However, it does seem possible that this group should constitute three-quarters of the operative cases rather than one-quarter, as in the present report. This simple change without alteration of the operative or hospital regimen would salvage a great many lives. In the present series it would allow theoretically 64 five-year cures out of every 100 operative cases, rather than the 40 obtained at present.

Much of this gain is the doctor's responsibility. He must carry out many boring and time-consuming breast biopsies if this gain is to be accomplished. Many biopsies will be for benign lesions but if lives are to be saved the diagnosis must be made while the lesion is merely a lump and without the accepted earmarks of cancer.

In this connection it should be pointed out that this policy is quite at variance with those who advocate frozen section as the most desirable means of diagnosis.[8] If a frozen section has been ordered, the patient must be admitted to the hospital and cannot keep her outpatient status as she might for excisional biopsy under local anesthesia. The entire setup, patient, operating room, blood bank and pathologist must be readied. It must be admitted by everyone that before all this preparation is set in motion the lesion is usually more than one of suspicion. It is no mere lump, it usually has some of the *earmarks of cancer*. For that type of lesion the frozen section may be all right or necessary but for the unsuspicious, unexplained lump an excisional biopsy is far more preferable. We must accept the drudgery of breast biopsies if we are to improve the results of breast cancer therapy.

A few years ago Haagensen and Stout[1] set forth certain criteria of operability for cancer of the breast. In part, their thorough presentation was an attempt to formulate rules which might act as a guide in determining whether a given advanced case was suitable for radical mastectomy or might best be treated by x-ray. This critical survey has been of considerable value to the treatment of our patients and has emphasized the limitations of the radical operation. Because of its importance we would like to list briefly those contraindications to operation as stated by Haagensen and Stout.

1. Pregnancy or lactation
2. Extensive pig skinning
3. Satellite skin nodules
4. Intercostal or parasternal nodules
5. Edema of arm
6. Supraclavicular metastasis
7. Inflammatory (acute) cancer
8. Distant metastasis
9. Two or more of the following:
   a. skin ulceration
   b. skin edema (less than ⅓ of breast)
   c. fixation to chest
   d. axillary nodes, 2.5 cm. or more
   e. fixation of proved axillary nodes

As will be noted, half of the points made are those which are generally considered as contraindications to operation. However, the remaining items are not so considered by most surgeons. Certainly the radical operation has been stretched to include far too many patients, and will continue to be unless contraindications in borderline situations can be better understood. With this in mind the above criteria were applied to the present series.

It was disappointing to learn that our cases did not completely parallel the Presbyterian Hospital series. The points listed formed a valuable guide as to operability but there were enough exceptions to prevent complete acceptance. There were 59 operated patients in the present report who should not have been treated surgically if the Haagensen-Stout rules had been followed. Two-thirds of these were dead at three years. Nevertheless, there were 15 percent who were alive at the end of five years.

An inquiry into this group revealed that none of our patients survived in which the first eight contraindications applied. All our survivors occurred in the group which had fixation of the breast to the chest, plus ulceration or pig skinning. It seems probable that our definition of fixation does not correspond to that of the Presbyterian group. Possibly if agreement could be reached as to just what degree of limitation of movement constitutes "fixation," then the prognosis here reported would be as black and discouraging as that indicated by Haagensen and Stout.

One point is clearly evident in this study. Too many patients were subjected to a radical mastectomy and might better have been treated by the x-ray department. Where the line should be drawn is not entirely clear but for the present those criteria listed seem as good as any.

In this study numerous correlations were attempted as to size of original mass, duration, site and age. No important deductions could be made. In general, the larger tumors had a poorer prognosis but there were numerous exceptions. As mentioned by many others, the growth originated in the upper outer breast quadrant in a high per-

cent. Ulceration of the breast indicated a grave prognosis but by itself was by no means all-decisive. In agreement with the general impression and in contrast with others,[5] the younger patients had a poor outlook. All of nine patients thirty-one years or under were dead three years after operation.

The average time which our patients waited before seeking professional advice after noticing a lump in the breast was 11.2 months. In a few of our cases adequate care was actually delayed by members of the profession waiting for a more typical lesion to appear.

SUMMARY

1. Little gain has been made in the treatment of breast cancer in the last few decades except for a clearer realization of the limitations of surgery and of x-ray therapy.

2. The present lay cancer campaigns have posed a new problem for the profession. The general public has accepted the dictum that "early cancer is curable." This is as it should be but it is embarrassing to realize that by "early" the public means the onset of symptoms whereas the statement refers only to the onset of the neoplasm, whether it gives symptoms or not.

3. Most cancer of the breast as seen in tumor clinics is advanced. In the present report 19 percent were inoperable. In three-quarters of the remaining cases the disease had already reached the axilla. This leaves only about one in five cases which is early cancer (confined to breast).

4. The excellent cures obtained in early breast cancer are reemphasized. The black outlook in the advanced lesion suggests that too many of these cases are receiving radical mastectomies. Some criteria such as those suggested by Haagensen and Stout should be used in gauging whether a given advanced case should be operated upon or receive x-ray therapy.

5. It is suggested that without any change of our present methods or change of attitude on the part of our patients, a considerable salvage of breast cancer lives could be brought about. This would mean biopsy of all unexplained lumps, not just lumps which are clinically suggestive.

Such a routine would be troublesome for the patient and boring for the surgeon. It would mean the biopsy of many cystic breasts with the finding of only very occasional cancer. It would, however, pay in finding early breast cancer and hence save lives. At present no other line of attack can offer so much.

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SKIN CANCER

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CANCER of the skin has a relatively high incidence among the general population, providing the examining physician has a high index of suspicion. True, it may be found at any age, but the beginning of its frequency is in the decade between 40 to 50 years of life, and increases as the span of years lengthens.

The rate of cancer of the skin is highest in white males with neoplasms and, according to statistics, ranks sixth in the white female. Skin carcinoma in the colored race is extremely rare. However, the finding of other types of cancer is for all intents the same as in the white race.

The death rate in this country from carcinoma of the skin is estimated to cause 6 percent of the total deaths due to cancer.

In the future, cancer of the skin will become more important in the United States on account of the increased life expectancy brought about by the overall excellent medical care the people of the country receive under our way of life.

Exposure to the elements, particularly to the sun's rays, has been proven to be a very significant factor in the incidence of skin cancer. Observations and statistics among both the white and colored races have shown the actual number

of skin cancers in the southern border states, Texas, Florida, Georgia, and Louisiana, to be much greater than in the northern states of Michigan, New York, and Pennsylvania. Blondes, red or reddish-haired persons, with inherently less pigment of the skin, have a higher rate than the brunette type of the white race.

Certain employed groups in which the persons are exposed to tars, pitch, certain petroleum products, and other chemicals, bring up considerably the total percentage of cancer of the skin. Employment with exposure to chemicals, actinic rays and other carcinogenic factors is frequent in Indiana, thus providing very fertile sources for the development of skin neoplasms right in our midst.

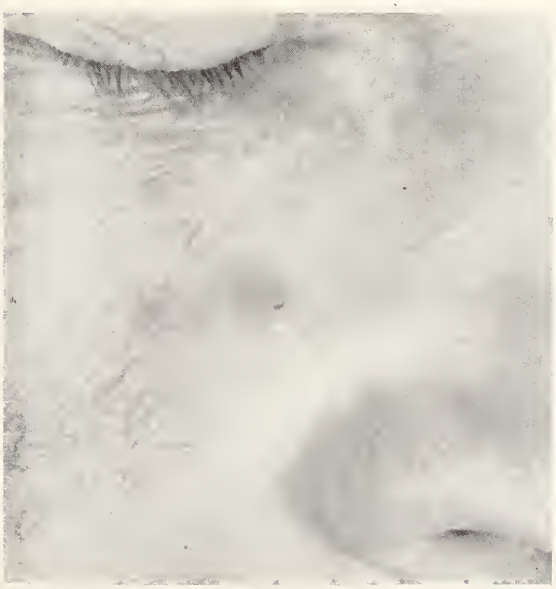
For all practical and useful purposes in considering the common types of carcinoma of the skin, we have the **Basal Cell Carcinoma**, the **Squamous Cell Carcinoma** and **Metatypical Carcinoma**. The clinical diagnosis by experts of skin carcinoma is estimated to be 80 to 90 percent correct when followed by microscopic examination of the biopsy specimen.

In the following paragraphs more pertinent data pertaining to the individual types mentioned will be noted.

BASAL CELL CARCINOMA (BASAL CELL EPITHELIOMA)

Basal cell carcinoma may arise from apparently normal or previously altered skin. Its clinical appearance varies with the age of the patient, duration, location, previous treatment, trauma, the amount of tumor parenchyma, the degree of reaction in the connective tissue, the direction in which the neoplasm spreads, and secondary complications such as ulceration or infection.

Figure 1.



1. Typical basal cell carcinoma with pearly nodule and crusting at upper margin.

Figure 2.



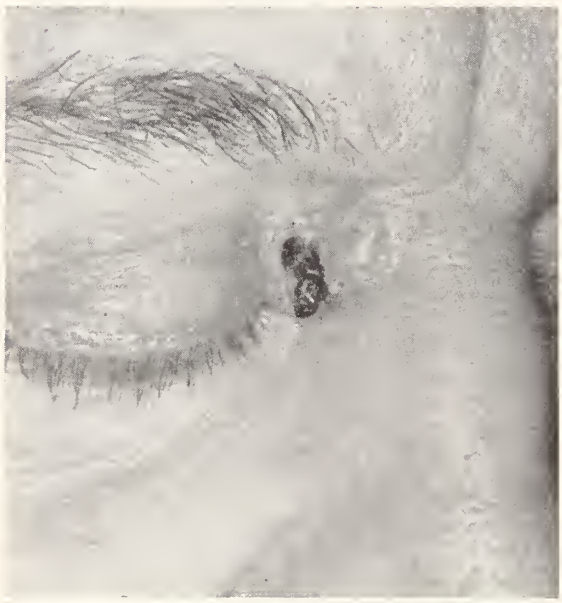
2. Basal cell carcinoma with typical button-like lesion formed by coalescing pearly nodules.

A typical basal cell carcinoma or epithelioma usually begins as a pin head to a slightly larger, waxy or pearly papule. Enlargement is gradual by the development of the papules, either waxy or pearly in color, which coalesce and form a plaque-like lesion. This growth progresses slowly; crusting becomes evident in the central portion and continues to form until it is quite noticeable. The crust comes off or is picked off, with a varying amount of bleeding occurring, and a new one forms. The process is repeated for months or years, depending upon the rate of growth, until an ulcer is formed. This ulcer has a typical rolled, pearly border with or without telangiectatic vessels radiating outward. Superficial or deep ulceration may occur. Pigmentation in the lesion may be slight or present in a considerable degree. Multiple lesions of the basal cell variety are commonly found on one individual. It is thought that pure basal-celled skin cancers do not metastasize. In the more advanced stages of basal-cell new growths, the appearance of the tumor may vary somewhat, but enough of the clinical characteristics as described are present to make the diagnosis.

Clinical descriptive names are often given to the lesions. We find the basal-celled cutaneous cancers described as rodent ulcer (the most common type), nodular, morphea-like, fungating, pagetoid, flat, rose-like, superficial, cicatrizing, and adenoid cystic.

The overall picture from biopsy studies shows the basal-cell carcinoma to be the most common of skin cancers. They occur chiefly upon the upper

Figure 3.



3. Basal to intermediate carcinoma at inner canthus with ulceration, crusting, irregular plaque formation.

two-thirds of the face, particularly the temples, forehead, scalp, nose, and eyelids, although they may arise on any part of the body. Their growth is usually slow and the lesions may be large or small. Pain is not a factor in carcinoma of the skin.

SQUAMOUS CELL CARCINOMA (PRICKLE CELL CARCINOMA OR EPITHELIOMA)

A squamous cell carcinoma arising in normal skin presents a lesion, which in the beginning may be so similar to the early basal cell variety that it cannot be distinguished from it clinically. However, different clinical characteristics soon become evident which may offer a clue to the cellular structure. At times, a definite diagnosis can be made only by microscopic examination.

Figure 4.



4. Multiple firm hyperkeratotic crusts, the largest of which has a squamous cell carcinoma at its base.

The clinical course of prickle cell carcinomas varies greatly. Some of them grow slowly and remain localized for years. Others change suddenly from slow to rapid growth, infiltrate the underlying structures and metastasize into lymph nodes. Some cases of squamous cell carcinoma show these malignant qualities from the beginning. The growth usually appears as a single lesion.

Although both basal and squamous cell epitheliomas can begin on apparently normal skin, the squamous cell type most often appears on a site altered by a previous lesion, such as a scar from a burn, lupus vulgaris, lupus erythematosis or syphilis, chronic ulcers, keratoses (arsenical or senile), cysts or leukoplakia. In contrast to basal cell carcinoma, squamous cell carcinomas often begin on mucous membranes and mucocutaneous junctions.

The usual clinical course of a squamous cell epithelioma is that it begins on the skin as a dry, wart-like growth that arises from an indurated base which is firm, frequently dull red or telangiectatic. The horny, or cornified out-growth from its center is really an inherent part of the tumor being formed; it is attached firmly to the skin and is quite hard to remove. In this manner, it differs from the crust that covers an ulcerated basal cell epithelioma. Cornification is a distinct property of the squamous cell variety. In time, however, due to accident or other trauma, the warty portion is pulled or knocked off. Bleeding occurs, and either another horny out-growth appears or an ulcer develops. In the early phase, this tumor is localized, elevated, and freely movable on the underlying structures. Later, it gradually becomes more diffuse and is fixed. As a rule the growth invades the underlying tissue, but it may remain superficial and bulky. The edges are hard and often everted, while the surface is cauliflower-like and secondarily infected. Extension is chiefly into the adjacent tissue, but may go to the regional lymph nodes.

Areas of predilection for the squamous cell type are the mucous membranes, mucocutaneous junctions and extremities, but they may occur anywhere on the skin. Squamous cell epithelioma involving the penis, vulva or anal region is clinically similar to squamous cell carcinoma in other sites of the body.

Squamous cell lesions are more numerous in male subjects and have a tendency to appear a little earlier in life than the basal cell variety. Neither of these, however, should be followed as an absolute guide.

METATYPICAL CARCINOMA (TRANSITIONAL CELL EPITHELIOMA) (MIXED CARCINOMAS)

According to statistics, 12 to 20 percent of all cutaneous carcinomas are either the mixed or intermediate type. These neoplasms, like the other

types, can occur on any skin surface. Microscopically, they consist of basal and squamous cells which may occur side by side, or a transitional structure with elements not typical of either variety. Although their clinical appearance may resemble that of basal cell carcinoma, their course is sometimes similar to that of the squamous cell type. The very fact that such a large percentage of this variety of skin carcinoma occurs shows the importance of a microscopic examination of every carcinomatous growth.

PROGNOSIS

The several types of skin cancer vary in their malignancy. The small basal cell epithelioma is often so benign as to be of little consequence, and even if it grows it is usually destructive only locally. Therefore, in the overall picture, the prognosis is favorable; if it is neglected, however, it may cause hideous mutilation, destruction, and death.

Cutaneous cancer of the prickle cell variety is much more serious. There is a greater tendency towards early dissemination, hence its prognosis depends upon many factors: grade of malignancy, location, age of patient, tumor bed, duration, radiosensitivity, invasiveness, and metastases. The outlook must always be guarded. A routine follow-up of each case is most urgent and should be insisted upon. Of all cancer cases, skin cancer when treated early offers the highest rate of cure.

BIOPSY

Time has proven that a properly conducted biopsy is without danger. It is recommended that each lesion and patient have the benefit of a microscopic examination by an experienced histopathologist, even to the extent of serial sections when indicated.

PROPHYLAXIS

To date, there is no certain method of preventing the development of skin carcinoma. Many cutaneous epitheliomas are preceded by a precancerous lesion for a number of months, or even years. Hence, the prompt removal of such would prevent the development of cancer.

TREATMENT

There is no one best therapeutic method for unselected cases of cutaneous cancer. The day when the physician or surgeon treated all cancers of the skin by the method with which he was most familiar is over. Each case must be judged individually by the clinical and laboratory findings. The advantages and limitations of the various methods must be weighed in regard to the case which presents itself. Any method or combination of methods may be best for the particular individual patient. A comprehensive therapeutic ability plus clinical skill is the demand of the day. If the physician cannot carry out the treatment of choice, he should refer the patient to someone who can.

Figure 5.



5. Squamous cell carcinoma with typical raised nodule and central ulceration.

The one essential principle is that whatever the form of the treatment, it must be applied so that every malignant cell is removed or destroyed. Another important factor for the physician to note is that the one who originally treats the cutaneous cancer has the highest percentage of cure in his favor, not the second or third one who works on it. A timorous approach cannot be tolerated when one is dealing with cancer. Cosmetic results cannot be placed above the possibility of a cure.

The therapeutic methods which have proved successful include scalpel surgery, electric knife,

Figure 6.



6. Carcinoma of the lower lip, squamous cell type, with extension to mucocutaneous surfaces.

electrocoagulation, actual cautery, chemosurgery, topical radium, interstitial radium (needles or radon seeds), and x-ray.

When some form of radiation therapy is to be used, a good auxiliary procedure is to curette the lesion prior to radiation. By this means the greatest part of the lesion is removed, its size definitely known, and a better exposure to the irradiation is available. Too often the value of curettement as an aid is underestimated.

If cooperation of the medical and lay people can be obtained, the excellent results in the treatment of skin cancer should be bettered and the present 6 percent mortality rate further decreased.

347 W. Berry St.

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SARCOMA ARISING IN PAGET'S DISEASE OF BONE AND MALIGNANT TRANSFORMATION IN A MIXED TUMOR OF THE SALIVARY GLAND

CASE REPORT

ELGIN P. KINTNER, M.D.

MISHAWAKA

From the Laboratory Service, Veterans Administration Hospital, and under the helpful direction of Harold Gordon, M.D., Chief, Louisville 2, Ky. Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are a result of his study and do not necessarily reflect the opinion or policy of the Veterans Administration.

NEARLY 100 years ago Sir James Paget studied and described the clinical entity of the bone disease which now bears his name. He was able to follow eight of the twenty-three cases observed to their death and found that five of these died of a malignant disease, three of carcinoma and two of sarcoma. This led him to conclude that this high incidence of malignancy probably had a direct relationship to the bone disease.

Since then it has been shown that a higher incidence of sarcoma of bone is present in patients with Paget's disease than in the general population of a similar age group. Approximately 7.5 percent to 10 percent[1, 2] of all cases of Paget's disease may be expected to develop sarcoma of the involved bone. On the other hand, of the small number of patients over fifty years of age with osteogenic sarcoma, 28 percent develop on the basis of preceding Paget's disease.[3]

The following case of Paget's disease of bone is being reported because of the unique association of sarcoma developing in bone and almost concomitant development of carcinoma in a mixed tumor of the parotid gland. Each, for over twenty years a relatively benign lesion, underwent separate malignant transformation within a year's time.

Clinical Abstract:

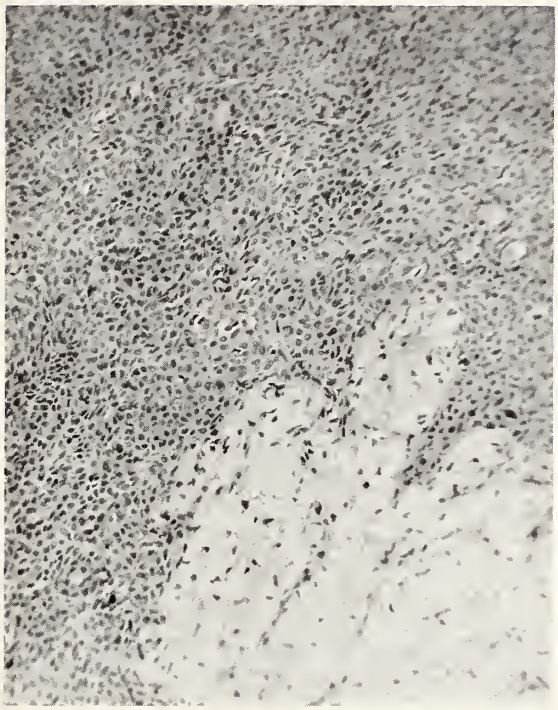
The patient was a fifty-six year old, white policeman who, although having impaired hearing for the past ten years, had "enjoyed good health" all of his life until January 1948, at which time he suffered a myocardial infarction. During his subsequent forty days hospitalization, a mild diabetes was discovered which was easily controlled with diet alone. His mother and two sisters also had diabetes.

On April 28, 1948, the patient had an accident and sustained a compression fracture of the fourth cervical vertebral body. During the hospitalization for this injury, attention was called to a mass in the region of the left parotid gland. The patient related that a tumor had been removed from the same region twenty years ago; however, ten years ago it began to recur and within the past year it grew rapidly in size. The tumor was again removed on June 2, 1948, and microscopic examination revealed a mixed tumor of the salivary gland, with malignant transformation, (Fig. 1) (AFIP No. 210927).

X-ray studies of the parotid gland prior to its removal (Fig. 2) showed, in addition to the abnormality in the parotid gland, a very advanced Paget's disease of the skull. A survey of the skeleton revealed similar involvement of the iliac bones and the twelfth dorsal vertebral bodies. Pertinent laboratory data at this time included: Kahn, negative; calcium, 11.0 mg/100 ml; inorganic phosphorus, 3.1 mg/100 ml; alkaline phosphatase, 10.9 Bodansky units.

Although the patient made a good recovery during this hospitalization, his head began to enlarge

Figure 1.



A photomicrograph of the tumor of the parotid gland. Two portions are noted: in the lower right half is a myxomatous area and the remaining portion is made up of diffusely proliferating nests of poorly differentiated carcinomatous cells.

rapidly, pains in the head became constant and annoying, and he was troubled with staggering and incoordination. A mass developed in the occiput and over the right eye. Pains in these regions became severe, coma ensued and death, associated with terminal pneumonia, occurred on May 18, 1949.

Necropsy Abstract:

The calvarium, (Fig. 3) weighed 1,700 grams and varied in thickness from 1.5 to 4.0 cm, but the bone was not dense. A large firm neoplasm that was present in the left occiput had invaded the meninges and replaced nearly one-half of the left cerebellar hemisphere due to compression. There was a similar tumor growth over the right eye. Pressure atrophy of the brain had occurred in several areas due to thickening of the skull.

There were firm metastases in the lungs together with extensive pneumonia. The heart had a healed infarct in the anterior wall of the left ventricle, and there was a tumor thrombus caught in the chordae tendinae of the tricuspid valve. The gallbladder contained stones and the arteries were markedly sclerotic generally.

Microscopic findings:

Sections of the calvarium showed typical changes of Paget's disease of bone. The tumors of the skull and the metastases were chondrosarcoma with ossification in some areas. A parathyroid gland had a small area of oxyphil proliferation. Some kidney tubules had calcium salts deposited in the tubules.

Comments:

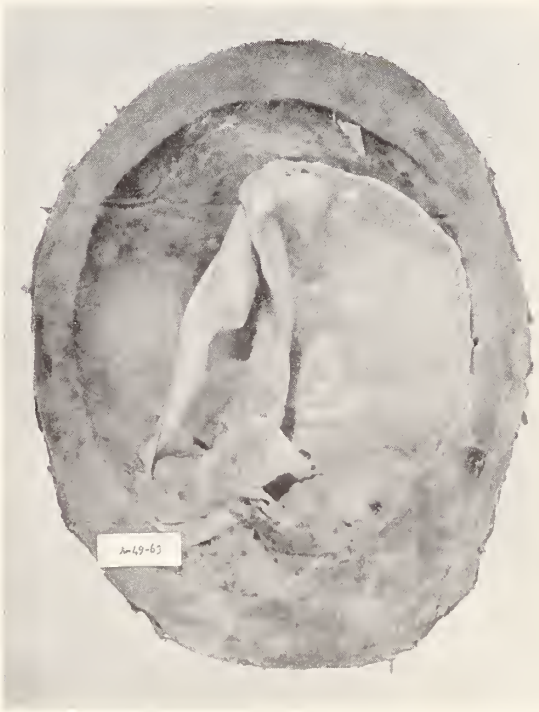
The cause of the malignant transformation in the two long-standing diseases is unknown, but in timing, it would seem to come from a single common factor of health. The microscopic characteristics of the sarcoma are unusual in that the predominantly chondromatous type is seldom encountered. Of seventy-six cases of sarcoma arising in Paget's disease of bone collected by Summey and Pressly,[4] nearly one-third were diagnosed as osteosarcoma, one-seventh as fibrosarcoma and only four cases as chondrosarcoma. The re-

Figure 2.



Lateral view of the skull showing advanced Paget's disease of bone. There are osteoporotic and osteoplastic bone changes. At the lower center is a lipiodol study of the left parotid gland, showing wide separation of the ducts where the tumor is situated.

Figure 3.



The calvarium with the dura stripped. In the lower left margin is the point of sarcomatous transformation. The light areas represent fibrous proliferation and the dark areas rich vascular stroma.

mainder were variously described as round cell, giant cell, mixed cell and sarcoma. Newman[5] reported two additional cases of chondrosarcoma arising in Paget's disease. The presence of mild diabetes mellitus and the history of familial diabetes is interesting, in view of the observations of Moehling and Abbott[6] who showed that diabetes is often associated with Paget's disease of bone.

Summary:

The case history and autopsy findings are presented of a patient with Paget's disease of bone, who developed concomitant carcinomatous changes in a long-standing mixed tumor of the parotid gland and sarcomatous changes in bone. The bone tumor was chondrosarcoma with atypical endochondral bone formation and fibrous proliferation. Marked brain damage was caused by compression both from the tumor arising in the occipital bone and from general bony overgrowth of the skull. The patient was a mild diabetic and had sustained a myocardial infarction eighteen months before his demise.

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CYTOLOGICAL EXAMINATION REVEALS EARLY UTERINE CANCERS

Microscopic studies of smears taken directly from the uterine cervix and cervical canal are extremely useful in detecting early uterine cancer in women, according to two Cleveland physicians.

Drs. James W. Reagan and R. T. Schmidt, University Hospitals of Cleveland, report on the effectiveness of this so-called cytological technic in the January 13 *Journal of the American Medical Association.*

In a controlled series of tests, specimens taken from 108 proved uterine cancer patients were examined by this technic. Affirmative results were reported by Drs. Reagan and Schmidt in 103 of the 108 proved cases.

The accuracy and effectiveness of this method require a highly skilled microscopist trained in cell research. In addition much care must be taken in obtaining the specimen and in preparing the tissue spreads for examination.

The report said: "The cytological technic is useful in the identification of uterine neoplasms and may reveal the presence of lesions unrecognized with the use of endometrial curettage or cervical biopsy."

CARCINOMA OF THE BILIARY TRACT

J. S. Battersby, M. D.*

INDIANAPOLIS

FOR PURPOSES of discussion carcinoma of the biliary tract is conveniently separated into four divisions. These divisions are made upon an anatomical basis, (a) the intrahepatic biliary tract; (b) the extrahepatic biliary tract including right and left hepatic duct, common hepatic duct and common bile duct; (c) the gallbladder; and (d) the ampulla of Vater. Carcinoma of the intrahepatic ducts or carcinoma of the liver will not be considered in this discussion.

GALLBLADDER

A review of the recent literature suggests that carcinoma of the gallbladder constitutes from 3 to 10 percent of all carcinoma. Graham[1] reported an incidence of 8 to 10 percent for carcinoma of the gallbladder in a study which included all neoplasms proved either by surgery or autopsy. From a study of 13,300 autopsies Kirshbaum and Kozoll[2] found an incidence of 3 percent. Cole[3] in a study which included a review of the literature placed the incidence of gallbladder carcinoma at 4.5 percent of all carcinoma found in the body.

The gallbladder has a very rich lymphatic network which permits a direct spread of the neoplasm to the adjacent liver and lymph nodes. While direct and early metastasis may occur, it is by no means invariable, as the neoplasm may grow slowly and diffusely infiltrate the gallbladder wall. Histologically the neoplasms are adenocarcinomas most frequently but scirrhous carcinomas may occur. In a relatively few instances squamous carcinoma may occur as the result of squamous metaplasia of the gallbladder mucosa. Of the cases studied by Sainburg and Garlock[4] 78.7 percent occurred in the 5th and 6th decades and there was a sex ratio of 5.2 to 1, females predominating. This is an age and sex incidence which closely parallels the age and sex incidence for cholelithiasis.

Much interest has been demonstrated in the role that cholelithiasis plays in the etiology of gallbladder carcinoma. Here again differences have been recorded. Rolliston and McNee have found that in 4 to 14 percent of all cases of cholelithiasis one may expect to find carcinoma of the gallbladder while Graham and his associates place the figure at 8.5 percent. Faucett and Reppman in a survey of 592 cases of gallstones found carcinoma in 12.5 percent. It is well demonstrated that cholelithiasis has associated with it a statistically significant incidence of carcinoma of the gallbladders.

A study of equal importance concerns the frequency of associated cholelithiasis in cases of carcinoma of the gallbladder. In this respect the inter-relationship of carcinoma and gallstones is more striking. Sainburg and Garlock[4] in a report of 75 cases of carcinoma of the gallbladder found cholelithiasis in 73.3 percent of the cases studied. The true incidence in this study is a higher figure inasmuch as the study on 13 percent of these cases was not complete or the autopsy report failed to specifically indicate the presence or absence of cholelithiasis. This observation and high incidence of carcinoma associated with gallstones is substantiated by the experience of Finney and Johnson.[5] It can certainly be said without equivocation that carcinoma of the gallbladder is associated with a statistically significant incidence of cholelithiasis.

The symptoms associated with carcinoma of the gallbladder are usually insiduous in their onset. An analysis of a large group of cases suggests that pain located in the upper abdomen is present in 70 percent or more cases.[4] The pain may be gradual in onset, or it may have an onset quite similar to that associated with cholelithiasis. A history of definite weight loss may be present in 40 percent of patients. Jaundice may be present in 38 percent of cases studied. Other symptoms such as anorexia, chills and fever, and vomiting have been present with less regularity.

Physical findings are not constant. Often palpation discloses a mass in the right upper quadrant of the abdomen, but equally as often only tenderness may be present.

X-ray and laboratory studies offer little or no help in establishing the diagnosis. X-ray studies of the gallbladder may reveal a non-functioning gallbladder. If jaundice is present the blood studies will be indicative of an obstructive type of jaundice.

The majority of patients with carcinoma of the gallbladder come to exploratory laparotomy. This surgical intervention although often early with respect to the duration of symptoms is relatively late in the course of the growth of the neoplasm. Often the spread of the growth is so extensive as to exclude the possibility even of any palliative procedure. When possible an excision of the gallbladder together with a wedge of liver, or excision of the gallbladder and involved portions of the extrahepatic biliary tract may offer palliative results. Roentgenologists agree that irradiation has little to offer in the treatment of this neoplasm.

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The prognosis for survival with a neoplasm of the gallbladder is very poor. The survival time usually ranges from six to eight months after symptoms have become well established. It is possible to find sporadic reports of survival for longer periods of time in exceptional cases where the diagnosis has been made extremely early or where the neoplasm has been discovered as an incidental finding at operation for cholecystectomy. A mortality rate of 98.5 percent in less than three years after operation makes this disease extremely refractory to treatment.

It is the hope that the future will hold a more favorable method of treatment for this neoplasm. In view of the observed facts that the incidence of cholelithiasis in carcinoma of the gallbladder is 69 percent to 100 percent[1] with other series showing 72.6 percent[2] and 80 percent[6] and 73.3 percent,[4] it seems proper to institute preventative measures. It has been noted that the incidence of carcinoma associated with cholelithiasis is 3 to 14 percent while the mortality of 1.6 percent[6] to 0.6 percent has been reported for cholecystectomy for all patients. It seems to follow that cholecystectomy for cholelithiasis may be indicated as a preventative measure as long as the mortality for the surgical procedure is far less than the incidence of the neoplasm. In the light of present day knowledge, and the inability to cure carcinoma of the gallbladder once the neoplasm is established, it seems proper to direct more attention to cholecystectomy in cases of cholelithiasis whether the stones produce symptoms or are the so-called silent stones.

CARCINOMA OF THE EXTRAHEPATIC BILE DUCTS

The incidence of carcinoma of the extrahepatic bile ducts has been placed at .0135 percent[7] of all cases of carcinoma studied at necropsy. The clinical incidence, which includes cases in which a diagnosis has been established at the time of operation, but in which no autopsy was performed, has been placed at .056 percent[8] for the Cincinnati General Hospital.

The onset of symptoms may be abrupt though the onset is more commonly slow and insiduous. Pain is often a part of the symptom complex (55 percent). The pain is located in the right upper quadrant of the abdomen, but may also radiate into the back and shoulder blade as is characteristic of obstructive lesions of the biliary tract. Jaundice is a frequent physical finding, and is reported in at least 90 percent[9] of cases studied. Jaundice usually is progressive with evidence of complete obstruction of the duct system. This is contrasted to duct obstruction from gallstones in which the jaundice is most likely to be intermittent and to be associated with chills and fever. The presence of Courvoisier's sign on physical examination is found only in 26 percent of cases. If gallstones have been present in the gallbladder, the presence of a large dilated gallbladder is less likely than when they have not been present. Other symptoms are nausea, loss of appetite, loss of weight and only occasional chills and fever. This entire group of symptoms are quite similar to those associated with choledocholithiasis, the notable exception being the character of the jaundice. The laboratory studies which are most helpful are those useful in obstructive jaundice. X-ray studies of the gallbladder are of little value especially when jaundice is present. On very infrequent occasions a gastrointestinal series may demonstrate a small pressure defect in the duodenal wall. This deformity is not typical of a neoplasm of the duct system nor is it a common finding.

The histological study of tumors of the extrahepatic bile ducts indicates that adenocarcinoma is found most frequently. It may be either papillary or nodular in type. In a very few instances squamous carcinoma may be present probably as the result of a metaplasia of the ductile epithelium. Carcinoma of the duct system has two types of growth characteristics. The papillary type is prone to fill quickly and travel along the duct, or to cause early invasion of contiguous structures. The nodular type of lesion grows more slowly and at the same time incites a growth of fibrous tissue which may be responsible in part for the slow growth and relatively slow metastasis of this type of lesion. This later growth characteristic may contribute to a more favorable response to treatment.

Treatment for carcinoma of the extrahepatic biliary tract is radical excision when possible. This type of surgery is not possible when the tumor has extended well up into the intrahepatic ducts, or when the neoplasm has invaded the portal vein. The surgical procedure of choice is a partial pancreatectomy with a partial choledochoduodenectomy. X-ray therapy seems to offer little or no hope for a clinical cure with only a minimal palliative response. This tumor response seems the same irrespective of whether the therapy be of the conventional 250 KV type or the 1,000,000 volt therapy.

The prognosis for patients with carcinoma of the extrahepatic duct system is slightly more favorable than for carcinoma of the gallbladder. To be sure, in 80 percent of cases only an abdominal exploration without resection can be carried out. In an additional 10 percent some palliative procedure can be carried out and in a final 10 percent it is possible to carry out a radical resection of the lesion. Survival rates suggest a mortality rate of 90 percent within 2 years. A 100 percent mortality rate is reported for a 10 year survival period. However, a few sporadic cases with a long term survival of several years offer a glimmer of hope.

CARCINOMA OF THE AMPULLA OF VATER

The precise origin of carcinoma of the ampulla of Vater often is in doubt. It may originate from the ductile epithelium of the biliary tract as it enters the duodenum, from the epithelium of the duct of Wirsung, or from the duodenal mucosa. Irrespective of the point of origin of the neoplasm, the symptoms are the same.

Carcinoma of the ampulla of Vater causes symptoms similar to those of carcinoma of the rest of the extrahepatic biliary tract. There are one or two notable exceptions found. If the tumor mass, although small in size, obstructs the pancreatic duct, evidence of pancreatic insufficiency may be present. The absence of pancreatic enzymes in the bowel may produce diarrhea. At times mild symptoms of pancreatitis may be present. Carcinoma of the ampulla of Vater is most often confused with neoplasms arising in the head of the pancreas.

Laboratory studies helpful in the case of this neoplasm are those useful in obstructive lesions of the extrahepatic bile duct. In addition to these studies the prostigmine-serum amylase test for pancreatic function may suggest an obstructive lesion to the pancreatic duct. Stool studies are nearly always positive for occult blood as ampullary tumors are prone to bleed.

X-ray studies of the gastrointestinal tract may be of value when positive findings are present. The reverse figure 3 sign is often found as a deformity in the duodenum as a result of the projection of the tumor of papilla of Vater into the lumen of the duodenum.

The treatment for this lesion is a radical surgical excision. Carcinoma of the ampulla of Vater is relatively slow to metastasize. This and the relatively small tumor that is required to produce symptoms help contribute to an earlier diagnosis than is the case with carcinoma of the pancreas. Carcinoma of the pancreas grows rapidly and metastasizes early.

Radical excision is necessary if cures are to be obtained. The best surgical procedure is a partial pancreatectomy and partial choledochoduodenectomy. A trans-duodenal excision of the lesion and reimplantation of the duct offers the patient little more than palliation. The prognosis for carcinoma of the ampulla of Vater when treated by radical resection is more favorable than either carcinoma of the gallbladder or carcinoma of the extrahepatic biliary tract. Only small series of cases of carcinoma of the ampulla of Vater have been reported. Siler and Zinninger[8] report eight proved cases with a resectability rate of 50 percent. It is encouraging to note that a number of patients have survived for several years though the 10 year mortality rate is 87.5 percent.

SUMMARY

Carcinoma of the extrahepatic biliary tract prepresents an extremely poor outlook for cure. Once symptoms of carcinoma have developed the disease has often progressed to a stage where even palliation is not possible. A notable exception is the lesion at the ampulla of Vater. Such lesions are somewhat more amenable to treatment.

Cholelithiasis is associated with carcinoma of the gallbladder in as many as 14 percent of cases. More significant is the fact that in carcinoma of the gallbladder gall stones are present in at least 80 percent of cases. In view of the inability to establish an early diagnosis of carcinoma of the gallbladder and effectively treat it, preventative efforts should be employed. It seems proper to suggest that efforts be directed to a more aggressive attitude towards cholecystectomy for gallstones as a means of reducing the incidence of carcinoma of the gallbladder.

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EVERY DOCTOR'S OFFICE A CANCER DETECTION CENTER

THE American Cancer Society and the Indiana Cancer Society have been instrumental in highlighting the importance of the family physician in the early diagnosis of malignancy. By adopting the slogan "Every Doctor's Office a Cancer Detection Center" they are calling attention to the responsibility which is borne by every doctor, specialist or nonspecialist, in regard to the detection of cancer in its early and more curable phase.

Ample testimony, to the effect that such a program is feasible and can be eminently successful, is reported in *The Journal of the American Medical Association* in the issue of February 3, 1951, by Dr. A. C. Siddall, of Oberlin, Ohio.

Dr. Siddall reports on the results of 1,650 examinations which were carried out on 950 presumably well women over a period of six years. Thirteen malignancies were detected in this group, as well as 225 benign conditions for which treatment was indicated.

The results in this group are purely the product of a system of periodic complete physical examinations of nonsymptomatic patients. Doctor Siddall diagnosed 13 malignant conditions in patients who presented themselves with symptoms during the same period of time, but does not include these in his detection series.

The success of the program is evidenced by the fact that the number of return visits has steadily increased from year to year. It is interesting to note that Doctor Siddall's county medical society sponsored the cancer detection method upon which he reports, after it had, for various reasons, discontinued a cancer detection clinic which it had sponsored previously. Forty-two members of this county medical society have signified their willingness to perform complete physical examinations for the detection of cancer.

Over 80 percent of all cancers can be found by inspection and palpation. This is the reason that the private practitioner should be able to detect cancer in his office.

EARLY DIAGNOSIS OF GASTRIC CANCER

EVERYONE who is interested in the problem of cancer of the stomach must, at some time, have realized a sense of futility in regard to its curability.

In common with many other malignancies, cure of gastric cancer depends on radical surgical removal during the early development of the tumor, when it is confined entirely to the stomach.

Surgical treatment, of course, must be preceded by diagnosis. Early diagnosis of carcinoma of the stomach is indeed a problem. The disease produces very few or no symptoms early in its course, and the symptoms it does produce are those which also are produced by a large variety of benign and relatively harmless conditions of the stomach and other organs.

This baffling situation has led to the recommendation that every patient who presents any symptoms which might indicate a malignant growth in the stomach should have a diagnostic study of the stomach by x-ray. Also periodic roentgen examinations of a screening variety have

been performed on non-symptomatic individuals to determine whether such a method would be practicable for purposes of early diagnosis. Either of these procedures probably would be too expensive for universal application.

Dr. Edwin Lawrence, in the lead article of this issue of THE JOURNAL, suggests the use of a comparatively simple and well known clinical test, to be performed with a view to selecting patients with gastric symptoms who should be investigated by barium meal.

The performance of the occult blood test on the stools of patients on meat free diets should go a long way in determining which individuals have ulcerating and bleeding lesions of the gastrointestinal tract.

This is a clinical test which may be performed in any doctor's office and if applied to patients with dyspeptic symptoms will be a considerable aid in selecting those who should be investigated for malignancy of the stomach.

CLASSIFICATION OF CERVICAL CANCER

IN ORDER to promote the use of a uniform system of classifying carcinoma of the uterine cervix, a joint committee of three American gynecological organizations has proposed a modification of the League of Nations classification, and is urging its universal adoption.

In 1937 the Health Organization of the League of Nations suggested a numerical system to indicate the clinical extent of lesions of cervical carcinoma. Since then many countries have followed this suggestion. It has not been used exclusively in the United States.

In assessing the results of therapy in this important disease a uniform method of grouping the cases is essential. When results as obtained by various medical centers over the world are to be compared, it is evident that uniformity of classification will be a great advantage.

The following system of classification was the result of the deliberations of the joint committee together with the Editorial Committee, Annual Report of Results of Radiotherapy in Carcinoma of the Uterine Cervix, at the International and Fourth American Congress on Obstetrics and Gynecology in New York City in May 1950.

Stage 0

Carcinoma in situ—also known as pre-invasive carcinoma, intra-epithelial carcinoma and similar conditions.

Stage I

The carcinoma is strictly confined to the cervix.

Stage II

The carcinoma extends beyond the cervix, but has not reached the pelvic wall. The carcinoma involves the vagina, but not the lower third.

Stage III

The carcinoma has reached the pelvic wall. (On rectal examination no "cancer-free" space is found between the tumor and the pelvic wall.)

Stage IV

The carcinoma involves the bladder or the rectum, or both, or has extended beyond the limits previously described.

EASTER SEALS—1951

THE LAST hundred years have seen many weapons forged for use in the fight against crippling, but it is a paradox that we seldom think of them or their discoverers except in the presence of their failure. Surrounded by healthy and happy children, we have no thought of those toilers of the laboratory to whom quite possibly we owe the strength and well-being of our own children, and we are reminded of the great "microbe hunters" only when we see some unfortunate child deformed by a preventable disease.

In overcoming this paradox, the Easter seal for crippled children fulfills a useful function. It turns our thoughts not only to the crippled children who are with us, but also reminds us of the debt of gratitude we owe many great men, living and dead, for having created the means of preventing the crippling of hundreds of others who pass us on the street every day.

The fight against crippling is part and parcel of the eternal quest for truth, and though it may be interrupted temporarily when certain social forces get out of hand, the desire for truth is the one solid line we can hang on to when the gales of war blow loudest. We cannot abandon the fight against crippling simply because a few madmen have plunged the world into the possibility of war, one of the greatest cripplers of them all. Perhaps some day a social pathologist, profiting by the scientists' example will find a way to immunize the world against the virus of war.

The appearance of the Easter seal for crippled children is a happy reminder that there are certain constant human values and that there is a continuity of human desire to strive toward the light. We cannot all be heroes, either of the laboratory or the clinic or the battlefield, but most of us can afford to put Easter seals on our letters, and in this way make a very real contribution to the welfare of the community and state.

(From The Society for Crippled Children)

President's Page

CHANGING CONCEPTS IN NURSING

ONE HUNDRED YEARS ago this year one of the noblest professions in mankind's experience had its formal beginning. In that year beautiful Florence Nightingale, born in England of wealthy parents, gave dignity, order and purpose to the profession of nursing She was an esthetic young woman, reared in luxury, whose first thirty-one years were devoted to the social graces and fine living. It was from this atmosphere that Florence Nightingale in 1851 broke loose from her family and plunged herself into a career of nursing. This was the beginning of the transition of the nursing profession from one of disrepute to one which is now acclaimed and respected by all mankind. Miss Nightingale believed that she had been called by God for this work. This dedication of her life to this cause is one of the brilliant chapters in human history.

From that day of unbelievably foul wards, with filth and stench pervading every hospital, the nursing profession has come a long way. The modern nurse has risen to a high position of esteem in the minds of everyone and her profession is an enviable one. This is a monument to multitudes of high minded women who, through the years, have unselfishly dedicated themselves to the advancement of this noble calling.

Within the memory of most of us there was a time when there were adequate numbers of nurses over the country to take care of the needs of those who were ill or injured. But in recent years it has become apparent that there are not nearly enough nurses for these needs of today. Many factors account for this shortage. In the old days there were few careers open to a young woman aside from home-making. Teaching and nursing headed the list. But with the coming of the world wars women have found many places of usefulness in our modern society. Many of these vocations bring greater remuneration. Then, too, it must be realized that a new attitude has come over the face of the earth and has affected everyone to some degree. Whereas yesterday it was common to ask, "what can I do to serve?", today it is, "what is there in this for me?" This change of attitude has surely diverted many fine young women from nursing, a calling which had opportunity-for-service for its chief attraction rather than financial reward. Too, there has been a greatly increased demand by the American public for medical and health care. It has been estimated that the present shortage of nurses in America exceeds 50,000.

There are certain measures which might be emphasized in the hope of improving recruitment prospects in nursing. Since it is true that a disproportionally large number of our nurses come from rural and the smaller communities of the nation, efforts to enroll nurse candidates should be focused in these areas. In hospitals where negro nurses are trained it has been found that there is a tremendous interest among the negro race and these hospitals are able to enroll as many as the facilities warrant. The situation is serious enough that hospitals could well utilize the services of part-time nurses to a much greater extent than most are willing to do. The objections to their use can surely be obviated. And it is apparent that in many institutions improvement could be made by adopting a more democratic treatment of the nursing personnel. An increase in the rate of pay in some areas is imperative.

It has been felt for a long time by most people who are close to this picture that the only answer to attracting enough young women into nursing was to abbreviate their course of training. It is felt that learning to carry out the routine procedures of bedside nursing care does not require three years of hospital experience. Any high school graduate of average intelligence can surely learn these matters within a year of concerted education. The three year training course will someday be looked upon as a relic of the day when hospitals extended their instruction over a period of three years so that the hospitals might benefit from the nursing service these young women rendered. In the second and third year of this course scarcely more classroom instruction than one hour a day is provided by most hospitals for these students.

The answer then would seem to be a different classification of nurse whom we might call the practical nurse, who in a year's time may learn these routine procedures. This idea is rapidly growing in America. There are fifty-eight approved schools of practical nursing already in operation in this country and perhaps 300 or more unapproved such schools. Twenty-eight States recognize their status by granting them a license as a practical nurse. Our own State Legislature just passed such a law. One such school already exists in Indiana, being operated in Indianapolis under the auspices of the Indianapolis Public Schools and with the approval and hearty cooperation of the various organizations of registered nurses. This is the beginning of a new chapter in the history of nursing and offers much hope for a marked increase in the number of young women available for nursing service.

With the advent of this new classification of nurses it is recognized that there is an increasingly important field for nurses with a higher education. Such nurses are needed for the administration of nursing schools, for teaching and for the supervision of the various floors and wards of our hospitals. And such nurses are needed to carry on in the important field of research. This whole program does not contemplate a lowering of nursing standards but instead focuses attention upon the real needs of the situation.

With many new hospital beds urgently needed and many present beds closed because of nursing shortage, and with the public accepting a dangerously low standard of nursing care in some instances, it is the earnest hope of everyone that this problem will soon be solved.

Alfred Edison

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

TUBERCULOSIS AND STATE MEDICINE

Aneurin Bevan's latest battle on behalf of British state medicine is with a group of Scottish physicians. They want to know why, with tuberculosis sanitoriums in their own country making patients wait a year to 18 months for admission, Mr. Bevan doesn't send the sufferers to Switzerland, whose famous sanitariums are closing down for want of patients. His reply is that he hasn't the money for it.

The physicians complain that Scotland is the only country in Europe which has made no progress toward stemming tuberculosis. The number of reported cases, which the physicians say is a small fraction of the total cases, has doubled in the last 10 years. Edinburgh and Glasgow, which have some of the worst slums in Europe, are the particular plague spots.

These statistics cast doubt on the claims of the British Labor government that its austerity diet, forced on the people of Britain, has actually been good for them. Tuberculosis is most often a disease of the poor, and the poor have benefited most, if anyone has, from food rationing. But it is scanty diets, together with exposure to active cases, that cause most T. B. infections, and quite obviously the government hasn't been feeding its people enough to enable them to resist infection as successfully as they did in nonrationed days.

All of this might be merely another brief against state medicine if it weren't for the fact that in the United States we also depend upon state medicine to lead the fight against tuberculosis. The fact that cure or arrest of the disease requires long periods of rest makes it impossible for the citizen of low income to pay for his own treatment.

We are, it is true, making great strides toward eliminating tuberculosis as a major cause of death, but not nearly as great strides as are possible. In Chicago it often takes many months to find a bed for a tuberculosis patient. The result is that he may infect others before he is isolated, and when he does get a bed, the tragic fact sometimes is that his hospitalization only keeps him from spreading his infection further before he dies.

Nevertheless, we are making progress in spite of inadequate hospital facilities. The only difference is that our public health officials aren't socialists, and aren't subject to the vagaries of a government in which these crackpots endeavor to regulate every phase of human behavior.

—Chicago Tribune

AMA SCHOOL FUND

The move of the American Medical Association to set up a fund for the support of private medical schools, to head off further Federal subsidies which the doctors deplore, is interesting and laudable. Government has moved into many new fields for the reason, or at least on the pretext, that private sources were insufficient.

Whether the doctors can raise the kind of money required to maintain modern medical schools is another question.

If doctors and other citizens who recognize the dangers inherent in increasing Federal financing of education would support private educational institutions with adequate gifts and bequests, the trend might still be arrested. But there are not enough millionaires left to do it; the money must come from middle-income men who are willing to pay for what they profess.

—Los Angeles Times

WAITING FOR THE DOCTOR

One large and largely unnecessary item of expense in medical care is the time lost waiting for the doctor.

An appointment is made for a certain hour and the patient arrives at that time. He is kept waiting anywhere from 30 minutes to three hours for a consultation or examination which will, perhaps, take five or ten minutes.

The life of some physicians is a continuous series of emergencies and for these due allowances must be made. Their patients should, however, be notified that the appointment schedule is merely a guess and that they will have to wait.

Other doctors have their routine interrupted by few emergencies yet never are able to keep order in their appointments. There seems to be little connection between punctuality and the nature of the doctor's practice.

Generally speaking, a room full of patients, waiting endlessly for their turn, may be attributed to lack of business organization, or of common courtesy. It would not be too difficult, even for those called away by emergencies such as accidents, to notify their patients and thus save their time. Office girls could do this job automatically, if so instructed.

Doctors, in these times, are busy people, but so is everyone else and any system, or lack of it, which wastes time, is an imposition. This one also interferes with proper and timely care. Many a patient puts off or neglects entirely a visit to the doctor because he just can't find half a day to wait around.

—Evansville Courier-Press

WHY PUBLIC CANCER EDUCATION?

ROLLIS S. WEESNER*
INDIANAPOLIS

"Less frequently now than five years ago, but still on occasion, the prediction is made that consistent dissemination of the cancer danger signals among all segments of the public will create a generally morbid and fearful attitude toward the disease. An exact reversal of this development is observed frequently by cancer control workers in a position to watch the reaction to their efforts. Literature setting forth the symptoms is glanced over, laid aside and forgotten.



"Even such statements as 'Cancer, if ignored, will not regress or cure itself. It will kill you' have failed to arouse in many readers the importance of taking the simple precautionary measures that have saved many lives and can save many more. Gradually, but very gradually, the message that early diagnosis holds the key to many cures is taking hold. Many years evidently will be required to strike a balance between the abnormal fearfulness and the bland 'it can't happen to me' attitude that induces dangerous delays.

"Cancer control workers thus far have found indifference to be more of a problem than overfearfulness. The trend in the educational program has been toward a calm, conservative approach that defers to the oversensitive. This poses a problem concerning methods of arousing those who refuse to be aroused.

"Literature furnished by the Indiana Cancer Society, 325 Board of Trade Building, and the Marion County Cancer Society, 1101 West 10th Street, can be kept in every home as valuable reference material for alertness without casting shadows of grim fear over the household."

The above appeared recently in *The Indianapolis Sunday Star* and other metropolitan Sunday newspapers in other parts of the state. It is one of a series of weekly releases that has become a feature in these Sunday papers. When the "Star" missed two successive Sundays during the holiday season last year calls came to the editor as well as to the Cancer Society, wanting to know if the feature was to be discontinued and why.

The contents of these articles are prepared under the supervision of the Indiana Cancer Society with approval of the Cancer Committee of the Indiana State Medical Association. The purpose is solely to keep the subject before the public and to encourage people to obtain more definite information relative to cancer symptoms by requesting booklets from the Society. More than 15,000 requests have been filled in the past two years. Every effort is made to keep away from controversial statements or even to talk about the disease itself except insofar as necessary to keep up reader interest and acceptability by the newspapers. When such references are used they are always authenticated through medical literature or accepted authority.

CRITICISM OF PUBLIC EDUCATION

There has been criticism at times of the publicity and the methods used in publicizing cancer to the public. Some of this criticism has been justified and, thank goodness, we are no longer confronted on every turn by "one in eight will die" and "every three minutes somebody dies." The advertising experts and the majority of psychiatrists say this was necessary in the early stages to arouse people, and concluded that those affecting a neurosis from these methods would find something else to disturb their emotions if it were not cancer. There were cases, however, known to many of us where cancer patients and their families and friends were put to undue anguish by these reminders assailing their ears or vision more or less constantly.

Public education now takes the hopeful approach and cites the many persons living who might have died had they not seen their doctors early. The common symptoms of cancer are stressed and especially the time element between recognition of a symptom and the call to the doctor's office.

We are still confronted with the problem of nation-wide publicity reporting experiments or purely local detection programs, or some chemotherapeutic that leaves in the mind of the reader the impression that his community and his doctor should have these things at hand. Such publicity cannot be controlled on a local level. Neither can institutional releases that speak only of their own endeavors. More and more, however, emphasis at every level is being placed upon the family doctor's role in the detection of cancer. Cancer detection clinics will be referred to less and less and the doctor's office more and more.

EDUCATION IN HELPING

The prophet's words, "My people are destroyed for lack of knowledge," need not be true in enlightened America. Pamphlets, exhibits, texts, posters, films, radio, newspapers, magazines and personal counsel are regularly employed in an effort to create an intelligent, forewarned and forearmed public. The present cancer educational material is well screened and can withstand chal-

* Executive Director, Indiana Cancer Society, Inc.

lenge for truthfulness and soundness. That it has been effective few will deny. A recent study has shown that in one community the percentage of patients guilty of culpable delay before consulting a doctor has dropped from 44.3 percent in 1938 to 32 percent in 1948. The experience of many doctors in their own communities further bears out this fact.

WHY CANCER EDUCATION

In spite of spectacular advances of the medical sciences since the turn of the century there are many health and welfare problems still unsolved. Many of the health problems have been taken up by pressure groups that appeal for funds and for professional and lay leadership, thus creating competition and at times some frustration as to what is judicious and of greatest importance.

Cancer is unique in that it will not cure itself, that time is of critical importance in treatment and that its early signs are trivial. Cancer is among the most curable of the major causes of death. When properly treated while confined to the breast, 80 percent cures are possible, 70 percent of uterine cancer can be cured if treated early, and 75 percent of cancer of the larnyx while confined to one vocal cord.

Yet, because most cancer is not treated early the country-wide achievement of cures averages about 30 percent for breast, 20 percent for uterine and 15 percent for cancer of the larnyx. This lower rate is not because of lack of technical ability, but rather of delay between the appearance of cancer signs and the institution of treatment. This delay is primarily due to the patient himself, because it is the patient who first must recognize trouble and do something about it. The average delay with cancer of the larnyx is three and one-half months after persistent hoarseness is manifest. Men with cancer of the bladder wait five months after blood has appeared in the urine. Even delay in skin cancer averages 13 months.

The reduction in this critical delay is a major objective of cancer education. No biological test (yet), no legislation or professional prescience can help. It is, therefore, of pristine importance that the individual learn the commoner early signs and symptoms of cancer and take action when they appear. It is also imperative that an organization such as the American Cancer Society, at all of its levels, inform the public and constantly attempt through all available media to advance the knowledge known. If this were not done a major function and responsibility of the society would be in default.

MEDICINE WEATHERS STORMY LEGISLATIVE SESSION

Donald E. Wood, M.D. and Norman R. Booher, M.D.*

INDIANAPOLIS

THE good ship Indiana Medicine, although listing badly several times, successfully outrode a stormy sixty-one day session of the Indiana General Assembly. Only one bill having the official disapproval of the Council was enacted into law.

Although the chiropractors had a well-paid staff of lobbyists, and their patients and friends flooded legislators with letters and telegrams, the two chiropractic bills failed to pass in the Senate, where they were introduced. One bill would have divorced the chiropractors from the present Board of Medical Registration and Examination and given them a licensing board of their own. This bill would have made any future graduate of an "incorporated" chiropractic school teaching 3,600 classroom hours eligible for licensure. A chiropractor now practicing in Indiana, although unlawfully, would have been licensed by passing an examination, irrespective of how much education he had had. When the Senate committee amended the bill to require the chiropractic schools to meet educational standards of other accredited teaching institutions, the chiropractors tried to eliminate the amendment, and failing to do so, the author killed the bill by recommitting it to the committee. The chiropractors revealed their allergy to competent education. The other bill would have protected the illegal practitioner of healing by weakening the injunction procedure of the present Medical Practice Act.

*Co-chairmen, Committee on Public Policy and Legislation.

AUTHORIZES OPTOMETRIC COURSES

The Council-disapproved bill that became law grants authority to the trustees of Indiana University to establish courses in optometric training at Bloomington, if and when funds become available. The bill originally, before changed by a House committee, mandated the trustees to establish a School of Optometry, leading to the degree of Doctor of Optometry. As amended, the bill provides for courses, and a B. S. degree instead of an O. D. degree.

The bill increases the annual registration fees of optometrists from $8 to $25, $17 of which is earmarked for the university. This is expected to raise $10,000 a year. The Indiana Optometric Association, which sponsored the bill, plans to buy the clinic and laboratory equipment. The 1951-53 Indiana University budget does not include a special grant for teaching optometry, but the trustees can use money allotted to the university.

The legislature appropriated funds (in the budget bill) for a heart and cancer clinic building at the Indiana University Medical Center. The

clinic will be partly financed by funds from the United States Public Health Services. The medical center budget, too, includes funds for architects' and engineers' fees for planning a Science building. It is hoped that the 1953 legislature will appropriate money for construction of the building. This is necessary before the first year of medical training can be moved from Bloomington to Indianapolis.

PUBLIC HEALTH BILL DEFEATED

Two bills of special interest to the medical profession did not make the grade. One, a House bill to permit use of state funds for support of local full-time public health departments, was voted down. The other bill, which died in a Senate committee, would have permitted any doctor of medicine to practice medicine or do surgery in every tax-supported hospital.

Three physicians served in the session and were of immeasurable help to the profession. They were Senator Walter F. Kelly of Indianapolis, Representative William M. Cockrum of Evansville, and Representative Otis A. Kopp of Anderson.

A total of 785 bills were introduced during the session and 324 of them became laws. Approximately 80 percent of the bills contained an "emergency clause" which means they became effective immediately.

The bills of interest to the medical profession, names of the authors, and whether or not they carried emergency clauses, that were enacted into laws, follow:

SENATE BILLS

S.B. 17 (Garrett-Johnson)—Permits osteopathic physicians who have an unlimited license to practice medicine as well as regular doctors of medicine to examine and make recommendations for admission of patients to public hospitals, including hospitals which are the property of Indiana University.

S.B. 33 (Gardner-Laran)—Provides for the licensing of practical nurses by the State Board of Examination and Registration of Nurses. Sets the license fee at $15 and annual renewal fee at $2. Emergency.

S.B. 62 (Baran)—Provides that persons committed to mental hospitals by Lake County courts must be cared for temporarily in the county home instead of in county or city jails. Emergency.

S.B. 100 (West)—Mandates physicians to report all cases of epilepsy or similar disorders to the State Board of Health and the State Aeronautics Commission as a means of reducing air accidents. Emergency.

S.B. 145 (Bontrager)—Authorizes counties to grant financial aid to non-sectarian and non-political hospitals providing the hospitals' governing organizations include one representative each of the county council and the county board of commissioners. Emergency.

S.B. 209 (Bontrager-Martin)—Mandates the chief officers of United States government hospitals to report all cases of restored sanity among veterans to the courts. Emergency.

S.B. 227 (Baldoni-Beczkiewicz)—Amends a South Bend City Hospital law by adjusting the population limits to conform with the 1950 census change. Emergency.

S.B. 250 (Kelly-Garrett)—Mandates all schools to administer periodic hearing tests to all pupils in the first, fourth, seventh and tenth grades and to all transfer students and those suspected of having hearing defects.

S.C.R. 15 (Martin-McConaha) — Mandates state mental institutions to receive visitors on Sundays and regular holidays.

HOUSE BILLS

H.B. 82 (Diener-Downey)—Creates combined city-county health and hospital department for Indianapolis and Marion County. Controlling board will include two appointees of the county commissioners and three appointees of the mayor. Effective date of Act is July 1, 1952. Board empowered to provide a cumulative hospital building fund by a new property tax levy and to issue general obligation bonds bearing 5 per cent interest rate for a term of not more than 40 years.

H.B. 135 (Brennan-Davis)—Raises from $500 to $1,000 the amount which may be recovered by hospitals, physicians, undertakers and attorneys in cases under wrongful death statute when the victim dies without leaving widow, widower or children.

H.B. 182 (Kopp-Greene)—Makes it a lawful duty for local health officers to attend meetings, when requested to do so by the State Board of Health. Emergency.

H.B. 199 (Link-Utterback)—Creates courses in optometry at Indiana University and raises annual registration fees of optometrists from $8 to $25 a year. Emergency.

H.B. 204 (Hasbrook-Malinka)—Adds two laymen to Indiana Council for Mental Health to represent the public interest. Provides for commitment of mental patients from Larue D. Carter Memorial Hospital to other mental institutions. Sets the salary for superintendent of Carter Hospital at $15,000 a year and provides he shall serve as director of the Council. Exempts salaries of superintendent and other personnel of the hospital engaged in training functions from the pay scale established for other state hospitals. Emergency.

H.B. 274 (Norris-Malinka)—Provides procedure for the transfer of patients from the Indiana Hospital for the Criminally Insane at Michigan City and from other state institutions to the new Norman M. Beatty Memorial Hospital at Westville. Emergency.

H.B. 276 (Diener-Malinka)—Provides that criminally insane persons may be committed to the Dr. Norman M. Beatty Memorial Hospital at Westville. Emergency.

H.B. 289 (Long-Aders)—Allows any city owning a hospital to lease it to a nonprofit hospital association in the same county.

H.B. 290 (Long)—Allows counties to make appropriations to pay their share of the cost of a hospital operated by a non-profit hospital association, when there is no county hospital.

H.B. 371 (Cockrum-Heavers)—Creates new boards of managers for county tuberculosis hospitals in counties of 125,000 to 175,000 population. Provides for treatment of chronic and convalescent cases in such hospitals.

H.B. 382 (Sedwick)—Sets up procedure to attempt to collect money from indigent persons who are admitted to the Indiana University Medical Center Hospitals or to local public hospitals through county departments of public welfare. Emergency.

H.B. 449 (Aders-Long)—Allows admission to Northern Indiana Childrens Hospital of children with defects, diseases or deformities which are presumably curable or can be improved by medical or surgical treatment and those needing special study for diagnosis. Emergency.

H.B. 499 (Cronin-Birchler)—Permits Terre Haute to levy a special 7-cent tax to pay for the hospital care of indigent persons. Emergency.

H.C.R. 5 (Kopp-Cockrum)—Authorizes the Governor to appoint a five-member committee to study the possibility of expanding the Indiana University School of Medicine to turn out more doctors. Committee to report to Governor before 1953 General Assembly.

News Notes

Announcement has been made that **Dr. John Dettmann**, of Green Bay, Wisconsin, will become associated in practice with **Dr. Don Manuel**, at Edinburg. Doctor Dettmann is a former classmate of Doctor Manuel, at the University of Louisville School of Medicine. Following his internship at Milwaukee, Wisconsin, Doctor Dettman served in the army for two years before entering private practice.

Dr. Frederick Dettloff, of Greencastle, is taking special postgraduate work in cardiology at Tulane University in New Orleans.

Dr. Richard R. Fowler, of Bloomington, has been recalled to active duty in the Army. He reported on February 4 to the Brook Army Medical Center, at Fort Sam Houston, Texas.

Dr. D. L. Lutes, of Edinburg, has been appointed chief of staff of the Muscatatuck State Hospital. He assumed his duties on January 15.

Dr. Philip L. Smith, formerly of North Manchester, has become associated in the practice of obstetrics and gynecology with **Dr. Robert W. Wilkins**, in Fort Wayne. Doctor Smith is a 1944 graduate of the University of St. Louis School of Medicine, and interned at Indianapolis General Hospital. Following that he entered the Army Medical Corps, and following his discharge served a fellowship in obstetrics and gynecology at the Mayo Clinic.

Dr. Julius Schwieger, of Austria, is practicing medicine in Fort Recovery. A graduate of the University of Vienna, he practiced in Paris, France, during World War II. He came to the United States in 1948, and served as resident physician at the Longbeach, New York, Memorial Hospital, and as visiting physician at the Presbyterian Hospital Medical Center at Columbia University.

Dr. Arthur E. Guedel, formerly a member of the Indiana State Medical Association, and now a resident of Los Angeles, was voted the 1950 Distinguished Service Award of the American Society of Anesthesiologists at the Society's annual meeting in Houston. Dr. R. J Whitacre, the outgoing president, made the presentation and lauded Doctor Guedel for his outstanding work on anesthetic agents, and especially for his contributions in the field of physiologic factors in inhalation anesthesia.

Dr. F. S. Crockett, of Lafayette, chairman of the Rural Health Committee of the American Medical Association conducted a three-day conference of that committee in Memphis, Tennessee, beginning March 1. More than 500 persons attended the conference.

Dr. C. M. Gillespie, formerly of Youngstown, Ohio, has opened an office in Andrews for the practice of medicine. Doctor Gillespie has practiced in Indiana before, having served for ten years on the Whiting Board of Health.

CAMP ATTERBURY MEDICAL SOCIETY

Medical Corps Officers of Camp Atterbury have organized themselves into a Medical Society, which will hold regular monthly meetings at the Hospital. The third Wednesday of each month has been designated for the meeting; 8:00 P.M. in the hospital branch of the Officers Club (building 1006, in front of and slightly east of Hospital Headquarters).

Col. Merrill H. Judd, Chief, Surgical Service, U. S. Army Hospital at Camp Atterbury was selected as the Society's first president. He has issued an invitation to all physicians who wish to attend the meetings, and will receive applications from doctors who are interested in military medicine and wish to become members of the Society.

AEC RESEARCH GRANT

The U. S. Atomic Energy Commission has announced that it has granted a new research contract to Indiana University. Under the grant which will support the project until Jan. 31, 1952, Dr. Felix Haurowitz will investigate the "Mechanisms of the Combination of Antigen with Antibody."

Veterans Administration announces the appointment of Dr. Seymour Fisher as manager of its new 192-bed hospital in Phoenix, Arizona, to be dedicated June 10, 1951.

Dr. Fisher presently is manager of a temporary VA hospital now in operation in Phoenix. The temporary hospital is scheduled to be closed as soon as the new one is ready to admit patients, VA said.

Dr. Fisher has managed the present Phoenix hospital since August 30, 1950. For nearly four years prior to that time, he served as chief of professional services at the VA hospital at Fort Benjamin Harrison, Indiana.

INDIANA ACADEMY OF GENERAL PRACTICE

The 1951 Annual Scientific Session of the Indiana Academy of General Practice will be held in Indianapolis on April 10 and 11. The officers and directors of the Academy are issuing a hearty invitation to all members of the Indiana State Medical Association to attend the scientific meetings. There will be no registration fee.

All doctors and their wives may attend the luncheon on Wednesday noon and the banquet on Wednesday night. All meetings will be held in the Athenaeum, except the lecture on Tuesday night, which will be given at the Methodist Hospital in a joint meeting with the Indianapolis Medical Society and the Staff Society of the Methodist Hospital.

The scientific program is as follows:

Tuesday, April 10, 1951

Small Auditorium—Athenaeum

1:00- 1:50 P.M. George S. Bond, M.D., Indianapolis—"Coronary Artery Disease"

2:00- 2:50 P.M. Arlie Barnes, M.D., Mayo Clinic—"The Problem of Pulmonary Embolism"

3:30- 4:00 P.M. Round Table Discussion—"Cardio Vascular Renal Disease"

Evening

Methodist Hospital

8:00-10:00 P.M. Arlie Barnes, M.D., Mayo Clinic—(The Founder's Lecture) "The Effect of Cortisone and ACTH on Acute Rheumatic Fever" Joint meeting with Indianapolis Medical Society, Staff Society of the Methodist Hospital and I. A. G. P.—White Cross Guild Building

Wednesday, April 11, 1951

Small Auditorium—Athenaeum

10:00-10:45 A.M. Frank B. Ramsey, M.D., Indianapolis—"Hyperthyroidism, Comparative Treatment with Medicine, Surgery and Radio Active Isotopes"

10:45-11:30 A.M. Gordon W. Batman, M.D., Indianapolis—"The Orthopedics That a General Practitioner Should Do"

1:00- 1:50 P.M. William E. Gabe, M.D., Indianapolis—"Gynecology"

2:00- 2:50 P.M. J. P. Greenhill, M.D., Chicago—"Recent Progress in Gynecology"

3:00- 3:50 P.M. Hayworth N. Sanford, M.D., Chicago—"Problems in the Care of the Newborn"

4:40- 5:00 P.M. Question and Answer Period. Speakers of the Day Participating

Following a year of postgraduate work at the University of Michigan **Dr. Robert R. Kopecky** has begun the practice of medicine in association with **Dr. John W. Deever**, 4131 Shelby Street, Indianapolis. Doctor Kopecky graduated from the Nebraska Medical School and interned at the Methodist Hospital, Indianapolis.

Dr. Robert J. Lehman has accepted a position as assistant professor of psychiatry with the University of Louisville Medical School. In addition to teaching duties, Doctor Lehman will serve as chief of the Mental Hygiene Clinic and as associate psychiatrist in the Child Guidance Clinic of Louisville. For the past three years Doctor Lehman has been training at the Pilgrim State Hospital, Brentwood, Long Island.

A former Chicago physician, **Dr. Francis E. Sarver**, has moved to Fort Wayne to practice general and thoracic surgery. Dr. Sarver is associated in practice with **Dr. R. M. Bolman**. He is a veteran of World War II, having served for four years with the United States Air Force.

At a meeting on February 20 **Doctor Michael Shellhouse**, of Gary, was elected president of the Lake County Mental Hygiene Clinic Board.

AMERICAN GOITER ASSOCIATION

The 1951 meeting of the American Goiter Association will be held in the Deshler-Wallick Hotel, Columbus, Ohio, May 24, 25 and 26, 1951.

The program for the three-day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics and demonstrations.

The American Congress of Physical Medicine will hold its twenty-ninth annual scientific and clinical session September 4, 5, 6, 7 and 8, 1951 inclusive, at the Shirley-Savoy Hotel, Denver, Colorado. Scientific and clinical sessions will be given on the days of September 4, 5, 6, 7 and 8, 1951. All sessions will be open to physicians and other professional personnel. In addition to the scientific sessions, the annual instruction seminars will be held September 4, 5, 6 and 7. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

THE NORTHERN TRI-STATE POST-GRADUATE MEDICAL ASSOCIATION

The annual meeting of the Northern Tri-State Medical Association will be held at the Commodore Perry Hotel, Toledo, Ohio, on April 17, 1951. The meeting begins at 9:00 a.m. and lasts until 5 p.m.

The meeting is open to all M.D.'s and students of recognized medical schools on payment of the three dollar membership fee. The fee may be sent to Louis P. Harshman, Fort Wayne State School, Fort Wayne, Indiana.

CHICAGO DIABETES ASSOCIATION OFFERS CHILDREN SUMMER CAMPING FOR THIRD YEAR

"Holiday Home" at Lake Geneva, Wisconsin will be open to eighty diabetic children, ages 8 through 14, from June 25, to July 16, 1951. This camping period is sponsored by The Chicago Diabetic Association.

General information and applications are available on request. All inquiries should be addressed to the Chicago Diabetes Association, Inc., 950 East 59th Street, Chicago 37, Illinois.

Dr. Henderson Cited by Freedoms Foundation. President Elmer L. Henderson received two awards from the Freedoms Foundation. He was among the 800 American persons and organizations to receive its 100,000 Freedom Awards for outstanding contributions to freedom during 1950.

He received a fourth place award—$100—for his address, "Medical Progress vs. Political Medicine," which he delivered over a nationwide radio hookup during the annual A.M.A. meeting in San Francisco last June.

He also received a Certificate of Merit in the magazine class for his article, "Here's Health—the Voluntary Way," which appeared in the May, 1950, issue of the Reader's Digest.

All of the awards were presented in special Washington's Birthday ceremonies at historic Valley Forge, Pa.

—A.M.A. Secretary's Letter

"The Key to Peace"—an American classic. The physician who can find a few spare moments should read Clarence Manion's American classic, "The Key to Peace."

The American Legion was so impressed by the quality and the importance of Mr. Manion's dynamic and thrilling restatement of American principles that it is giving the 120-page book widespread distribution.

—A.M.A. Secretary's Letter

Dr. C. M. Harless, formerly of Chesterton, has moved his office to the former office of Dr. **Joseph** Dale, Chesterton, who has returned to Kissimmee, Florida, for health reasons.

VA ACCEPTS BIDS FOR RADIOISOTOPE LABORATORY

Bids for a radioisotope laboratory at the Veterans Administration hospital in Indianapolis are being accepted by VA's Central Office in Washington, D.C.

The 33,000-cubic-foot laboratory is to have concrete foundations, masonry construction above, and a built-up roof. In addition to actual construction, the project also includes installing laboratory equipment, plumbing, heating, ventilating, grading and other specified items.

VA WILL AID BATTLE CASUALTIES

The Department of Defense and the Veterans Administration jointly announced plans to hospitalize certain disabled military personnel in VA hospitals for specialized medical care, including rehabilitation on the same basis as other veterans with service-connected disabilities.

The military patients to be hospitalized by VA are those whose disabilities make it improbable that they will return to active duty. The transfer policy will not preclude the return to duty of any patient who, after medical treatment and rehabilitation, desires to return to active duty and is acceptable to the armed forces.

The basic consideration in transfers will be the welfare of the patient and each case must be considered on an individual basis.

The military patients to be transferred under the plan would have become eligible for VA hospitalization as soon as they were separated from the service. The new plan merely speeds their transfer and reduces the overall national demand for critical medical personnel by caring for patients in one organization instead of having the VA, the Army, the Navy, and the Air Force duplicating personnel and facilities.

The types of cases considered applicable for transfer are: severe injuries to the nervous system, including quadriplegics, hemiplegics, paraplegics; the blind and the deaf requiring definitive rehabilitation; major amputees; neurological disabilities, including poliomyelitis with disability residuals and degenerative diseases of the nervous system; patients requiring extensive plastic surgical procedures and those also requiring extensive thoracic surgical procedures. In addition to these categories the tuberculous and the neuropsychiatric patients, especially the psychotic, are recognized to be the largest group that will require specialized service in the Veterans Administration.

A.M.A. WASHINGTON OFFICE NEWS

Committee Completes 2-Year Study of U. S. Grants to Medical Schools. A special 12-man non-government committee, appointed by the Surgeon General of Public Health Service to investigate the effect of federal research grants on medical schools, has completed its two-year study. Its report includes the following conclusions:

1. PHS should alter its present awarding system, under which *a small group of schools gets a high percentage of research funds*, and distribute a portion of the funds geographically. "Dollar for dollar," the report points out, "research grants are more effective in stimulating research in smaller rather than in larger institutions. Diversity of support assures diversity of interest, philosophy, purpose and viewpoint."

2. "There is no logical reason" why PHS should continue to pay *total cost* of all projects it aids.

3. *Private support for research is not decreasing;* it should be developed.

4. Additional separate national institutes for such diseases as multiple sclerosis, diabetes and poliomyelitis are not desirable.

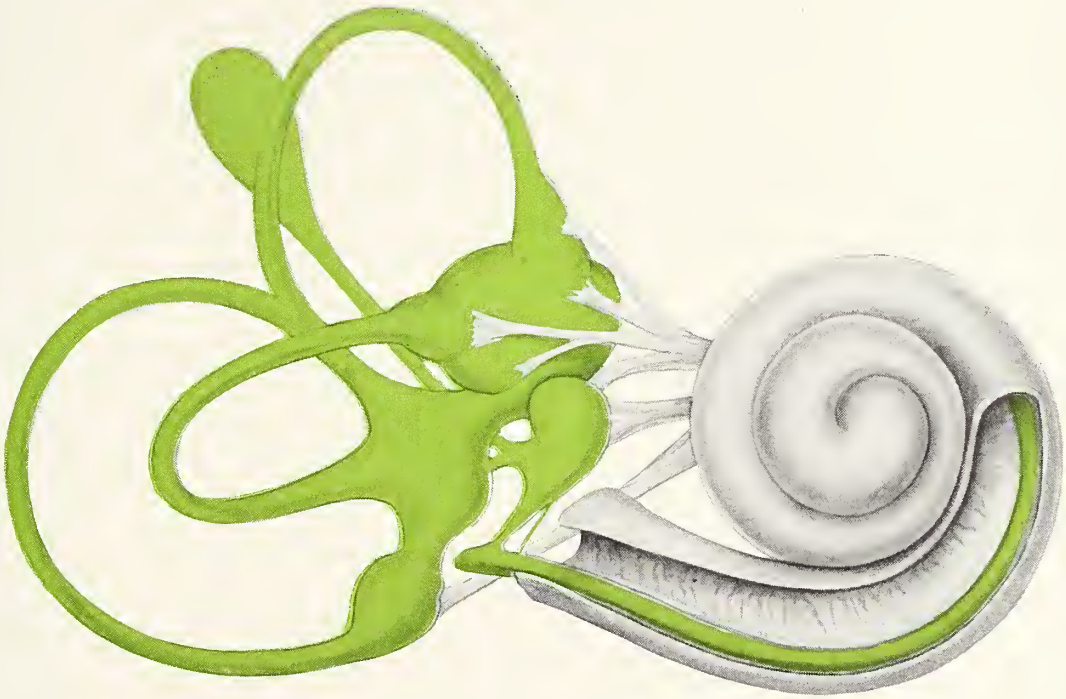
'Dilatory' Priority I Applicants Blocked on Higher Rank. Defense Department has straightened out a peculiar kink in commissioning regulations. It took action after learning that a few physicians *could eventually obtain a higher reserve rank merely by refusing at first to apply for a commission.* This is what is happening in some cases: "Doctor 'A' and Doctor 'B' both with two and one-half years experience in private practice are offered a commission on the same day. Doctor 'A' accepts and is commissioned a first lieutenant in the Army or Air Force, or a lieutenant junior grade in the Navy. Doctor 'B' declined and continues his practice for six months, at the end of which period he has the three years experience required for a commission as captain in the Army or Air Force, or lieutenant in the Navy." But from now on, qualifying experience may not be attained after the date on which pre-induction physicals are begun for a particular priority. In practice, Priority I physicians *who declined a commission* at the time of their physical may not count toward their eventual military rank *any experience acquired after December 6, 1950*, official date for start of physical examinations in Priority I.

Whole Blood Still Needed, NRC Emphasizes. National Research Council, which sponsors research in manufactured plasma substitutes, has warned that these substances cannot take the place of human blood in treating the injured. Any ideas like this, it said, are the result of a "dangerous misunderstanding."

In the background is the fear that wide publicity given to plasma substitutes—such as dextran and periston—will cause the public to lose interest in the national blood collection campaign of Red Cross. Dr. M. C. Winternitz, chairman of the Council's Division of Medical Sciences, said that to date the Red Cross campaign has kept up to its schedule. However, demands for blood are increasing rapidly, and any falling off of public support would create a critical situation.

"There is no real substitute for whole blood, and none is in sight," Dr. Winternitz said. "It is the best treatment for shock, regardless of cause. The council has stressed this fact repeatedly since early in the last war. When blood has been lost, or blood cells damaged—as by severe burns or atomic radiation—only blood itself can replace promptly what is missing."

Senate Committee Agrees to Approve Aid to Local Public Health Units. The Senate Labor and Public Welfare Committee is reported to have *agreed unanimously* to report favorably on S. 445, for federal aid to local public health units. Formal action is scheduled for this week. S. 445, identical with the bill approved by the Committee last year, in some respects is at variance with the House bill (H. R. 274), which the AMA Committee on Legislation has endorsed with certain recommended modifications. The Senate Committee will continue its study of S. 337, for *federal aid to medical education.* Discussion indicated the Committee may want to decrease the figure of $25,000,000 for construction, and to include in S. 337 some of the provisions for aid to nurses' education now contained in H. R. 910. Before the Committee took up S. 337, word was received in Washington that the *California Medical Association* had voted to contribute *$100,000* to the AMA-initiated campaign for private support of medical schools. AMA set up the fund with a contribution of $500,000, now being supplemented by pledges from individuals and other organizations.



Detail of the Labyrinthine Structure

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—Tuttle, A. D.: Special Breakdown of Case Histories, presented at the Airlines Medical Directors Association Meeting, New York, N. Y., Aug. 28, 1949.

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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Deaths

Burton D. Myers, M.D. dean emeritus of the Bloomington division of Indiana University School of Medicine, died suddenly at Bloomington, on February 28. He was eighty years of age. He had been dean of the medical school from 1927 to 1940. Doctor Myers was professor of anatomy since 1903 and became assistant dean in 1920. He was responsible for construction of the Kiwanis Wing at the Riley Hospital for Children. Since his retirement, he has written a history of Indiana University, from 1902 to 1937. Doctor Myers was active in state association affairs, having served on the following committees: Pathology, Medical Education, Scientific Demonstrations, Health, Public Instruction and Medical Publicity, Public Policy and Legislation, Scientific Exhibit, Medical Education and Hospitals. He had also served as a delegate to the American Medical Association.



Doctor Myers was a graduate of the University of Leipzig, Germany, in 1902. He was an honorary member of the Owen-Monroe County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

William E. Mendenhall, M.D., of Indianapolis, died on February 20 at the age of eighty. A graduate of the State College of Physicians and Surgeons, Indianapolis, in 1907, he had practiced in Indianapolis since that time. Doctor Mendenhall was a former member of the Indiana State Board of Health, a member of the Indianapolis Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

Lawrence W. Paynter, M.D., of Salem, died March 5 after a short illness. Although seventy-nine years of age he practiced medicine until the time of his death, and served the residents of Washington County for 58 years. Doctor Paynter was a graduate of the University of Louisville School of Medicine in 1893. He began medical practice in Campbellsburg and came to Salem in 1920. Doctor Paynter was a member of the Washington County Medical Society, the Indiana State Medical Association and the American Medical Association.

Charles W. Rauschenbach, M.D., of Hammond, died on February 17 at the age of sixty-one. He was a graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, in 1912. Doctor Rauschenbach served as a captain in the Army Medical Corps in World War I and then came to Hammond where he opened an office to practice roentgenology. He took several postgraduate courses, and in 1949 journeyed to South America to study tropical diseases. Doctor Rauschenbach was a member of the Lake County Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

Willard A. Price, M.D., aged eighty-three, died on February 16 after an extended illness. A recipient of the Indiana State Medical Association's Fifty Year Award, Doctor Price had practiced medicine and surgery in Nappanee since his graduation from the Medical College of Indiana, Indianapolis, in 1895. He was a member of the Elkhart County Medical Society, and honorary member of the Indiana State Medical Association, and an Associate Fellow of the American Medical Association.

Everett Wesley Richardson, M.D., of Winslow, died March 7 at his home after a short illness. He was seventy-three years of age. After graduating from the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, Doctor Richardson moved to Texas where he practiced until 1938, at which time he returned to Winslow.

Samuel R. Blackwell, M.D., of Gary, died on March 4 at the age of sixty-eight. He had been in declining health for some time. Doctor Blackwell was a graduate of the Meharry Medical College, Nashville, in 1913. He first practiced in San Antonio, Texas, coming to Gary in 1917.

To drain the flooded area

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1. Hutchesan, J. M.: Management of Cardiac Failure. *Virginia Med. Monthly*, 74:458, Oct., 1947.
2. Noth, P. H.: Pick's Disease: A Record of Eight Years' Treatment with Salyrgan, Ammonium Nitrate, and Abdominal Paracentesis. *Proc. Staff Meet. Mayo Clin.*, 12:513, Aug. 18, 1937.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

COMMITTEE ON PUBLICITY

January 19, 1951

Present: J. O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; D. S. Megenhardt, M.D., and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of March 4, 1951—"Improving Health is Dangerous"

Week of March 11, 1951—"We Kill Our Children"

Week of March 18, 1951—"T. B. Death Rate Drops"

Week of March 25, 1951—"Infant Nutrition"

Week of April 1, 1951—"Occupational Dermatitis"

The secretary reported that Dr. Robert E. Jenkins had agreed to speak to the Parke-Vermillion County Medical Society on Dermatitis."

The chairman reported that he appeared before the Council at its meeting on Sunday, January 14, and it was his understanding that approval had been granted for the publication of the pamphlet on Atomic Bombing and that the AMA Campaign Coordinating Committee would pay the cost of printing out of its budget.

The secretary reported that the Blue Cross and Blue Shield plans had placed an order for 800,000 of these books to be distributed through the State Civil Defense Council as an official publication of the Council. It is planned that the front page carry a message and signatures of the organizations sponsoring the publication. The Association has been invited to cosponsor the 800,000 for distribution through the Civil Defense Council plus the 200,000 planned for distribution through the physicians' offices. This would permit the name of the Association to appear on a total of one million copies. Upon motion by Doctor Hamer and a second by Doctor Megenhardt, the committee voted to approve the tie-in with the Hospital Association and the Blue Cross and Blue Shield Plans in this endeavor.

The layout and copy for another pamphlet entitled "Getting Well At Home" was given the committee for study as a future publication of the Association.

February 9, 1951

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; E. S. Megenhardt, M.D.; Frank B. Ramsey, M.D.; and James A. Waggener, field secretary.

Minutes of the meeting held January 19, 1951, were read and approved.

The Committee viewed the kinescope film of a television show produced by the Bureau of Health Education of the American Medical Association. The kinescope, "Dr. Webb of Horeshoe Bend" was approved for use over WFBM-TV on Saturday, February 10, 1951.

The following "Hints on Health" columns were approved:

Week of April 8, 1951—"Headaches"

Week of April 15, 1951—"Childbirth is Safe"

The secretary presented two new pamphlets now available from the American Medical Association.

There being no further business, the committee adjourned to meet again in the Headquarters Office at 4:00 p.m., Friday, March 2, 1951.

These minutes were approved as a whole and in each separate part on Friday, March 2, 1951.

COUNTY MEDICAL SOCIETY OFFICERS

CLARK COUNTY MEDICAL SOCIETY
President, George L. Regan, Sellersburg
Vice-president, Arthur Vandevert, Sellersburg
Secretary-Treasurer, Cecil L. Patterson, Charlestown

GIBSON COUNTY MEDICAL SOCIETY
President, Virgil McCarty, Princeton
Vice-President, K. S. Strickland, Princeton
Secretary-treasurer, Roland Weitzel, Princeton

HANCOCK COUNTY MEDICAL SOCIETY
President, L. B. Rariden, Greenfield
Vice-President, J. R. Woods, Greenfield
Secretary-Treasurer, Wayne Endicott, Greenfield

HOWARD COUNTY MEDICAL SOCIETY
President, R. A. Craig, Kokomo
Vice-President, R. W. Phares, Kokomo
Secretary-Treasurer, Guy Morford, Kokomo

LAPORTE COUNTY MEDICAL SOCIETY
President, C. N. Fischer, LaPorte
Vice-President, D. D. Oak, Jr., Hanna
Secretary-Treasurer, M. G. Meyer, Michigan City

PARKE-VERMILLION COUNTY MEDICAL SOCIETY
President, J. R. Bloomer, Rockville
Secretary-Treasurer, W. E. Britton, Montezuma

LOCAL SOCIETY REPORTS

Dubois County Medical Society members met at Jasper on February 8. Twelve members attended the meeting.

Franklin County Medical Society members held a dinner meeting at the Country Club in Connersville February 20. A feature was the talk by Dr. L. A. Stamper, Richmond dermatologist.



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Grant County Medical Society and its auxiliary enjoyed a dinner at the Hostess House in Marion February 22. Dr. A. A. Sullenger and Dr. Fred Dick, both of Marion, were co-chairmen.

Hendricks County Medical Society members held a luncheon meeting at Merritt's, near Avon, on March 6. Ten members heard Dr. Robert Howell, of Indianapolis, speak on "Urinary Disturbances."

Howard County Medical Society members met at the Frances Hotel at Kokomo on February 2, with twenty-six members in attendance.

On March 2 the twenty-five members present at the meeting at the Hotel Frances heard Dr. Lall G. Montgomery, of Muncie, speak on "Diagnosis of Chronic and Acute Pancreatitis."

Huntington County Medical Society members met on February 6 at the Hotel LaFontaine, in Huntington. The speaker for this meeting was Dr. Thomas James, Jr., of Huntington, who spoke on "Recent Improvements in Burn Therapy." The nineteen members present also participated in the cardiovascular postgraduate radio seminar.

Jasper-Newton County Medical Society members met at the Brook Hotel, Brook, the night of February 14. Dr. Louis W. Nie, of Indianapolis, was present and gave an address on "Convulsive Disorders seen in General Practice."

LaPorte County Medical Society members met at the Trail Inn, Michigan City, on January 18th. Dr. Milo G. Meyer, Michigan City, spoke on "Medical Military Manpower Requirements," and Mr. Karl Hilbert discussed "Civilian Defense." Thirty-two members attended this meeting.

On February 15 at a meeting at the Rumeley Hotel LaPorte, the guest speaker was Dr. H. H. Rodin, of South Bend, whose subject was "Skin Cancer." Dr. Herbert McMann, superintendent of the Norman Beatty Memorial Hospital, in Indianapolis, spoke briefly of the ultimate plans for the hospital. Twenty-four members attended this meeting.

Lawrence County Medical Society members heard the telephone seminar March 6 at a meeting in the Greystone Hotel in Bedford, following a dinner attended by twelve members.

Montgomery County Medical Society members held a meeting at the Culver Hospital, Crawfordsville, on February 15 for a showing of a moving picture on communicable diseases. Twenty-two members were present.

Putnam County Medical Society members met at Greencastle for a meeting on February 9. Dr. Lillian B. Mueller, of Indianapolis, presented a paper on "Anesthesia for the General Practitioner." Fourteen members were present at this meeting.

Vanderburgh County Medical Society members met on February 13 and all attendance records for that society were broken when 157 members turned out for the regular February meeting to hear an outline of the program developed for medical civil defense. Vanderburgh County is rapidly organizing for any emergency under the direction of Dr. W. Russell Springstun, chairman of the Medical Civil Defense Committee. Assignment of members for various activity is under way under the sector and block team system. In addition to the discussion on civil defense, Dr. J. Edward Tether of the Indiana University Medical Center gave a paper on "Myasthenia Gravis". The Vanderburgh County Medical Society recently approved a plan to present immediate past presidents with a gift in token of appreciation for their service, and to present all living past presidents wth certificates suitable for framing, attesting to their year of service. The first gift, a fine movie camera, was presented to Dr. Philip Yunker, president in 1950. The meeting was held in the Hotel McCurdy.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. D. E. Lybrook, Galveston.

President-elect—Mrs. F. M. Fargher, Michigan City.

Corresponding Secretary—Mrs. E. W. Bailey, Logansport.

Recording Secretary—Mrs. H. P. Sloan, New Albany.

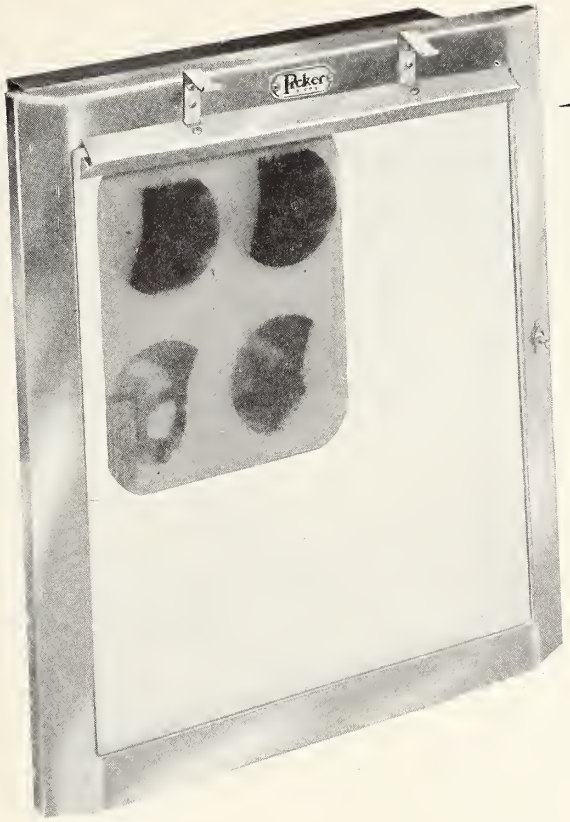
Treasurer—Mrs. Robert Bolin, Elkhart.

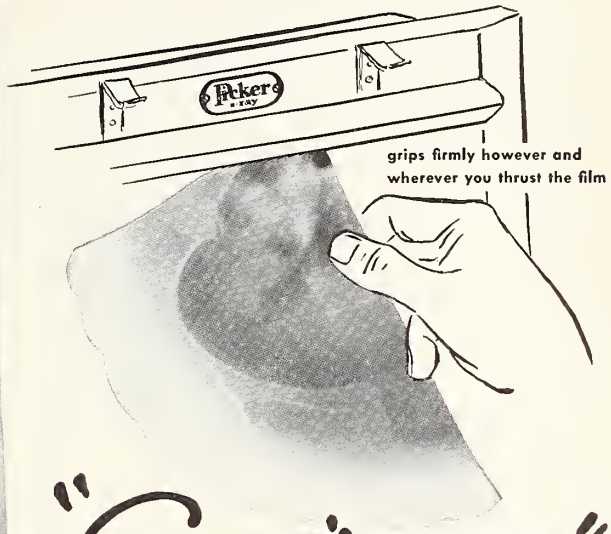
Publicity—Mrs. F. M. Gastineau, Indianapolis.

AUXILIARY TO MEET

A few more months, and the members of the Woman's Auxiliary to the American Medical Association will be arriving in Atlantic City, New Jersey, for their Annual Convention, June 11-14.

Have you made your reservations? If not, send your request *at once* to Dr. Robert A. Bradley, Chairman A.M.A. Housing Bureau, 16 Central Pier, Atlantic City, New Jersey.





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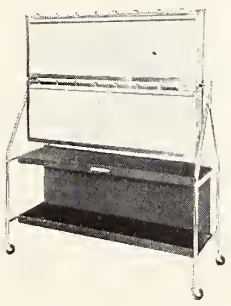
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BOOKS REVIEWED

THE ANTIHISTAMINES. Their Clinical Application. By Samuel M. Feinberg, M.D., associate professor of medicine, chief of Division of Allergy, and director of Allergy Research Laboratory; Saul Malkiel, M.D., assistant professor of medicine, director of research, Allergy Research Laboratory; and Alan R. Feinberg, M.D., clinical assistant in medicine, attending physician in Allergy Clinic, all of Northwestern University Medical School. 291 pages. Price $4.00. The Year Book Publishers, Inc., 200 East Illinois Street, Chicago, 1950.

The rapid development of the numerous antihistamines and the widespread use of these substances, not only by the medical profession, but by the layman as well, has made such a book as THE ANTIHISTAMINES, Their Clinical Application, a particularly timely addition to the medical scientific literature. The writers have made a fortunate division of material in their book, placing the more complex treatment of the experimental aspects of their subjects in the first five chapters, and the clinical observations in the remainder of the book. This permits a general practitioner whose chief Interest may be the clinical material and its application to his patients to use the book for his own purposes without the necessity of searching through what might have been a less orderly discussion of all aspects of the subject.

A practical part of the book is the Appendix, in which is listed all the numerous antihistamines (as of the time of publication) with the name of the manufacturer and the trade name, forms in which dispensed, and ingredients. A list of 586 of the thousands of references to the literature has been carefully selected by the writers to represent the various dependable sources of information for the reader who wishes to carry his reading and study beyond the necessarily limited scope of this handy little volume.

L. G. M.

A TEXTBOOK OF GYNECOLOGY. By Arthur Hale Curtis, M.D., emeritus professor and chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; and John William Huffman, M.D., associate professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago. Sixth edition. 799 pages with 466 illustrations, including 37 in color. Price $10.00. W. B. Saunders Company, West Washington Square, Philadelphia, Pa., 1950.

The development of this text book (the sixth edition) from the small book which Dr. Curtis wrote in 1930 has been extremely interesting. It is like a boy grown to manhood. The book is more than twice as large as the first edition and yet is a relatively small textbook. A remarkable feature of all of the books which Dr. Curtis has written has been his ability to present a vast amount of pleasantly readable material and facts without resorting to a lushness of verbiage. Dr. John Huffman, who has been associated with Dr. Curtis for many years, is a coauthor of the present edition.

The first chapter is on the anatomy of the female pelvis and perineum. Dr. Barry J. Anson, of the Department of Anatomy of Northwestern University, has prepared the material in association with Dr. Curtis. This is the most instructive and complete demonstration of anatomy of the female pelvis which has been published in this country since the monumental work of Howard Kelly and Max Broedel in 1898. Especially well illustrated in this chapter is the present-day conception of the supportive structure of the pelvic organs. The entire work is based on original anatomical research and should be reviewed by every pelvic surgeon.

The next seven chapters are devoted to the embryology and physiology of the generative organs. This material is entirely up-to-date and more easily understood than some texts on the subject. Regarding the therapeutic use of endocrine products, the authors display more mature conservatism than some writers. The section on infectious diseases is complete as to the description of pathology, etiology, prevention and treatment, which has been revolutionized by the advent of sulfonamides and antibiotics.

Two sections of the book are devoted to neoplasms of the pelvic organs. Tumors of the uterus are divided into chapters of: myomas; carcinoma of the cervix; carcinoma of the body of the uterus; and other tumors and hypertrophy of the uterus. The chapter on myomas considers thoroughly the development, diagnosis and treatment of these tumors. Here the author thoroughly considers all accepted treatments and concludes, as do most present-day gynecologists, that the great majority of myomas that require treatment at all should be treated surgically, and that irradiation is now rarely indicated for myomas.

The section on cervical carcinoma has not been revised as extensively as some of the other parts of the book. The illustrations and text for the most part consider advanced carcinoma. It appears that more emphasis could be placed on early detection of the disease. In this chapter there are a few statements with which all gynecologists may not agree. One is that most carcinomas of the cervix may be diagnosed by gross inspection without biopsy. Emphasis is placed on abnormal vaginal bleeding as the first symptom of cervical carcinoma. Unfortunately many cervical carcinomas are advanced before any vaginal bleeding occurs. This chapter would be enhanced by stressing routine periodic examinations of all women in the detection and control of cervical carcinoma; and also by encouraging the more extensive use of the vaginal smear and biopsy.

In discussing carcinoma of the body of the uterus, the author does not especially stress curettage as a diagnostic procedure. Most gynecologists would hesitate to make the diagnosis of carcinoma of the body of the uterus without curettage except in advanced cases.

The chapter on tumors of the ovary is a monograph in itself. One distinctive and desirable feature of this chapter is that the authors have made no attempt to give a confusing classification of ovarian tumors; they merely enumerate them. The illustrations in this chapter are outstanding, both the gross photography and the photomicrographs are excellently prepared. Almost every encountered tumor of the ovary is considered. This chapter, like all the chapters, concludes with a very complete list of references.

The remainder of the book thoroughly considers almost every gynecologic disorder. The whole text is clearly and authentically written, which makes it one of the finest textbooks on the subject of gynecology that has ever been written. The enormous teaching and practical experience, and the literary ability of the authors, permit only one appraisal of the book; it is outstanding. As a textbook it can be highly recommended to all practitioners and also to specialists in gynecology, but because of its comprehensive scope it may not be the choice text for the undergraduate student.

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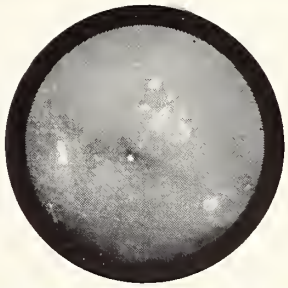


Photo taken after insertion of "RAMSES" Vaginal Jelly. Os occluded.

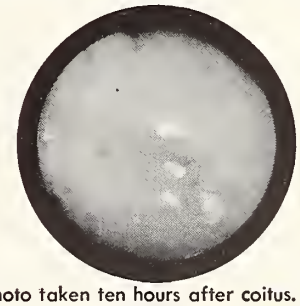


Photo taken ten hours after coitus. Occlusion still manifest.

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Relationship of Stress to Autonomic Lability

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance. [1,2] Such states may involve any one of the organ systems or several at one time. [1,3] The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifestations	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. 8,9,10.

1. Ebaugh, F.: Postgrad. Med. *4:* 208, 1948. 2. Wilbur, D.: J.A.M.A. *141:* 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. *42:* 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. *27:* 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. *107:* 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. *58:* 251, 1948.

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PATHOLOGIC PHYSIOLOGY: Mechanisms of Disease. Edited by William A Sodeman, M.D. The William Henderson Professor of the Prevention of Tropical and Semi-Tropical Diseases, Tulane University of Louisiana School of Medicine; Senior Visiting Physician, Charity Hospital of Louisiana; Consultant in Medcine, U. S. Marine Hospital at New Orleans. 808 pages with 146 figures and 30 tables. Price $11.50. W. B Saunders Company, West Washington Square, Philadelphia, Pa. 1950.

The subtitle, Mechanisms of Disease, seems to describe well the intent of the authors. Although the book is less technical than a standard book on pysiology, its applied physiology will be read with value by many who have not the time to dip into the more elaborate text.

The discussion of relaxation of the heart as being an active process better described as expansion, or expansibility, seems especially logical; likewise the explanation of how hypertrophy decreases the relative blood supply to the cardiac muscle. In the section on the electrocardiogram, Johnston has made a very lucid explanation of the ventricular gradient. The explanation of the Duroziez' sign as having both phases of the murmur due to forward movement of the blood is at variance with that taught in the older textbooks.

Castle's section on disorders of the blood is a 100 page monograph, in itself enough to justify the book. In the section on the kidney especially notable is the discussion on management of acute renal failure. The endocrine glands are presented in a very well integrated, though brief, fashion by Reifenstein.

The book would seem to have its greatest value when used as a stimulating refresher in one or another field rather than as a reference book.

S. L. J.

PHYSIOLOGY OF THE EYE. By Francis Heed Adler, M.D., professor of ophthalmology, School of Medicine, University of Pennsylvania. 709 pages, with 319 illustrations, two in color. Price $12.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis. 1950.

This book bears no resemblance to Adler's previous book "Clinical Physiology of the Eye," written some twenty years ago.

This work is completely new, authoritative and by an outstanding man in his field.

This should be a standard textbook for all residents in ophthalmology and will be a valuable reference book for research workers and physiologists.

Clinical application lies mainly in the field of muscle anomalies and glaucoma, as it is difficult to treat either of these conditions without understanding the pathologic physiology involved.

This is probably the best of the books in this field.

R.F.C.

PRACTICAL GYNECOLOGY. By Walter J. Reich, M.D., attending gynecologist Cook County Graduate School of Medicine; and Mitchell J. Nechtow, M.D., associate attending gynecologist, Cook County Hospital. 449 pages with 187 illustrations, including 55 in color. Price $10.00. J. B. Lippincott Company, East Washington Square, Philadelphia, Pa., 1950.

The title of this small volume, "Practical Gynecology," well befits the vast amount of practical material on the subject which it contains. Although

(Continued on page 332)

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MONTHLY REPORT—FEBRUARY, 1951

Disease	Feb. 1951	Jan. 1951	Dec. 1950	Feb. 1950	Feb. 1949
Brucellosis	1	0	6	0	2
Chickenpox	358	367	341	363	524
Diphtheria	2	5	7	24	29
Encephalitis	2	0	3	2	2
Erysipelas	1	0	2	3	4
Food infection	3	0	1	0	1
Impetigo	1	1	2	0	1
Influenza	64	51	97	37	52
Infectious hepatitis	11	4	3	17	0
Measles	624	211	85	676	372
Meningitis,					
Unclassified	5	7	8	8	6
Influenzal	2	1	1	0	2
Meningococcal	3	5	1	1	8
Mumps	182	167	82	161	163
Pneumonia	42	54	74	32	151
Poliomyelitis	4	5	1	0	3
Rabies in animals	49	19	33	55	74
Rheumatic fever	5	1	1	0	*3
Rubella	12	8	13	52	70
Scarlet fever	233	178	124	210	384
Tetanus	2	1	0	0	0
Tinea capitis	5	5	22	0	72
Trichinosis	1	0	0	0	0
Tuberculosis,					
Pulmonary	135	141	139	170	244
Other forms	9	13	11	14	15
Typhoid fever	4	2	2	3	3
Whooping cough	97	89	180	157	112

(Continued from page 330)

this is the first edition of the book, the material is not strange to many physicians; because the work upon which it is based is the personal observation and teaching experience of the authors at Cook County Hospital in Chicago. The vast amount of teaching material seen in this institution enabled them to give the subject a practical perspective.

The sequential arrangement of the material in the book follows the routine which is recommended in examining each individual patient. The first chapter is on the psychosomatics of gynecology and is in keeping with the current interest in psychosomatic medicine. This chapter is not long, but it clearly discusses the more common gynecological complaints in which the psychic element is the predominant etiological factor. Especially enlightening is the psychosomatic approach to sexual problems such as dyspareunia, frigidity and sexual incompatibility. The next three chapters consider at some length methods of gynecologic diagnosis. This is an unusually valuable outline for history-taking, general physical and gynecologic examinations. There is also an evaluation of the more common laboratory tests pertaining to obstetrics and gynecology. The directions for the examination of the breasts, which is an integral, but often neglected part of every gynecological examination, is unusually well illustrated and explained in the text. A chapter on reproductive endocrinology discusses endocrine physiology and considers the therapeutic use of endocrine preparations. The recommendations made here are all sound and are not colored by the over-enthusiasm of some writers on the subject.

In the chapter on dysmenorrhea, the use of stem pessaries sewed to the cervix is recommended. Most gynecologists today consider this treatment not only noneifficacious but frequently harmful. Symptoms ascribed to malpositions of the uterus in this book are considered more seriously than is justified by the experience of most gynecologists. It is the observation of most gynecologists that retroversion of the uterus is a very rare cause of backache, and also that one is not often justified in ascribing abnormal vaginal bleeding to that cause. Also, the statement is made that the uterus may be displaced by nonobstetric trauma. Such a statement would be encouraging to attorneys for plaintiffs in damage suits.

Almost every gynecological disorder with which the general practitioner may be confronted in his office is considered in this book. The illustrations are all very well prepared and are informative. The management of what may be termed minor gynecological disorders is sound and unusually well prepared. The section on premarital counsel is brief and, like the entire book, is extremely readable. It contains much valuable information which every practicing physician should be able to impart to his patients who are considering marriage.

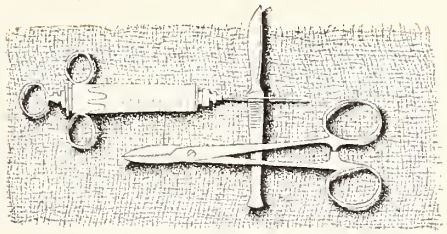
At the conclusion of the text, there is a section of remarkable colored plates depicting common gynecological lesions. Included in these are specimens of vaginal cytology demonstrating the hormonal response of the vaginal mucosa. This demonstration would be enhanced by smears showing malignant cells which is the most important field for vaginal cytology.

This book thoroughly covers the field of gynecologic diagnosis and office treatment; and the information which it gives is so reliable that it is highly recommended to general practitioners and students. D.A.B.

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CARDIOTOXIC ACTION OF INTRAVENOUS PROCAINE

FRED S. CARTER, M.D.,* LAPORTE

JACK L. EISAMAN, M.D.,‡ BLUFFTON

INTRAVENOUS PROCAINE has become a valuable therapeutic weapon in many widely separated pathological conditions. Our findings on its uses, parmacology, and toxicity have not been published. This report deals only with the cardiotoxic action of intravenous procaine.

Procaine has been widely used for its effect on the heart in anesthetized humans. It has been particularly useful in controlling ectopic pacemakers in thoracic surgery and in controlling ventricular arrhythmias encountered with various anesthetics, particularly cyclopropane.[1-10]

Edmonds, Comer, et al, recently reported marked circulatory depression as a hazard in the use of large doses of intravenous procaine during anesthesia.[11] Procaine has been said to be a myocardial depressant mimicking quinidine in its action.[12] This effect on the myocardium is used to depress ectopic pacemakers, thus allowing normal sinus rhythm to return. In spite of this knowledge no literature is available on the effects of procaine on the electrocardiogram of the unanesthetized human. Only limited work on mammalian hearts is available.[13, 14]

Uhley and Wilburne studied the effect of procaine on the ECG of dogs.[15] They used sodium pentobarbital to prevent convulsive reactions and injected procaine, 50 mgm/kg. in 15-120 seconds.

They noted: (1) P-R and QRS interval prolongation to the point of auriculoventricular and intraventricular block; (2) a tendency for the heart rate to increase or decrease, depending on the speed of the injection; (3) increased amplitude of the P waves; (4) reduction of the amplitude of the QRS complexes "in almost every instance," with the appearance of a deep S wave (in lead II) as intraventricular block developed; (5) increase in amplitude of the T wave independent of changes in heart rate.

They feel that procaine acts as a powerful depressant of conduction and has an additional direct effect on the myocardium in view of the QRS and T wave changes. They suggest that hearts damaged by inflammatory or degenerative diseases may tolerate only a fraction of the customary dosage.

We have studied forty-two cases by means of electrocardiograms before and immediately after procaine infusion. Two hundred and sixty-three procaine infusions were given and two hundred and fifty-seven electrocardiograms were made. The tracing made prior to the first infusion was considered the control. Tracings were made before and after each infusion in cases showing changes, and only after the infusion in others. The patients used were those receiving procaine therapy for various diseases.

In most cases procaine infusions were given daily; others received infusions on alternate days. Treatment was given until either an excellent therapeutic result was obtained or further infusions failed to improve the condition. Thirteen patients received intravenous procaine at the rate of 4 mgm/kg. in twenty minutes; twenty-nine received 1,000 cc. of 0.1 percent procaine intravenously in one hour.

The results are tabulated in tables one and two. Of the forty-two cases, thirteen (31 percent)

* Former Resident in Medicine, Caylor-Nickel Clinic and Clinic Hospital, Bluffton.

‡ Department of Medicine, Caylor-Nickel Clinic, Bluffton.

TABLE I
Electrocardiographic Changes Noted with Intravenous Procaine

Effect	Dose Administered		Totals for each effect (42 pts.)
	4 mgm/kg. (13 pts.)	1000 cc. 0.1% (29 patients)	
P-R Interval Prolongation	4	1	5
QRS Interval Prolongation	0	0	0
QRS Voltage Decrease	4	13	17
QRS Voltage Increase	1	1	2
T Wave Voltage Decrease	5	11	16
T Wave Voltage Increase	3	5	8
P Wave Alterations	1	3	4
TOTALS	18	34	52

TABLE II
Summary of Incidence of ECG Changes After Intravenous Procaine

Result	Dose Administered				Totals	
	4 mgm/kg.		1000 cc. 0.1%			
	Cases	%	Cases	%	Cases	%
Cases with no change	3	23 %	9	31%	12	28.5%
Cases with one change	4	30.6%	9	31%	13	31 %
Cases with more than one change	6	46.4%	11	38%	17	40.5%
Total Cases	13		29		42	

showed one of the changes classified by Uhley and Wilburne. Seventeen (40.5 percent) showed two or more changes. Only twelve (28.5 percent) showed no change during the course of treatment.

A comparison of the myocardial effects of the 4 mgm/kg. dose and the 1,000 cc. 0.1 percent dose (table II) reveals clearly that the smaller dose is equal to the larger in its myocardial depressant actions.

P-R interval prolongation was seen in five cases. L.B., a 67-year-old, white female, with combined arthritis and arteriosclerotic heart disease (thera-

Figure I

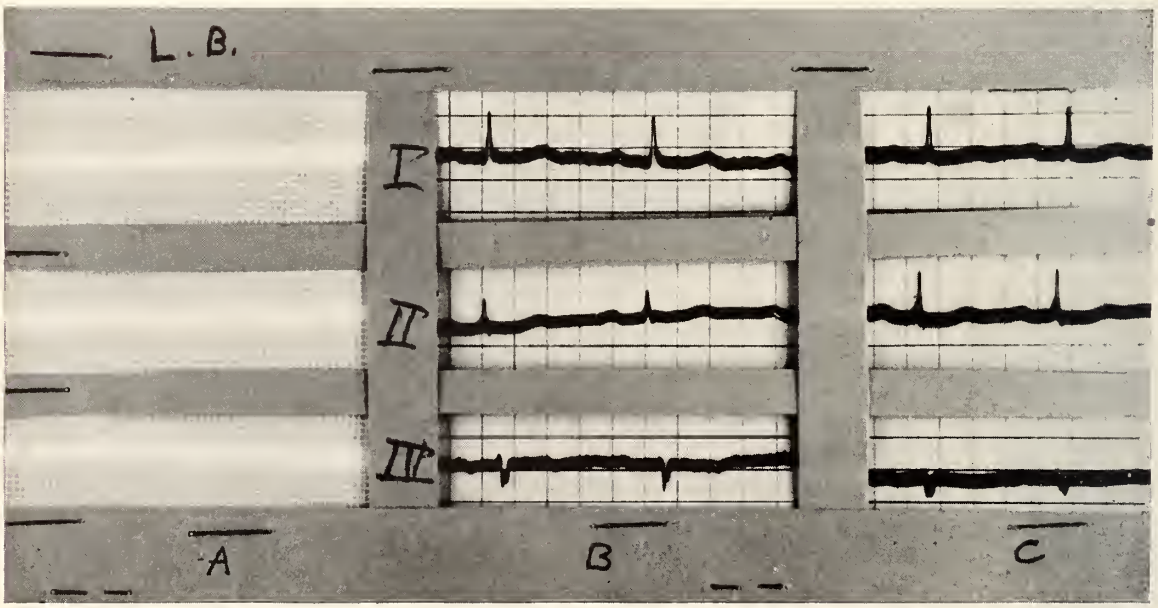
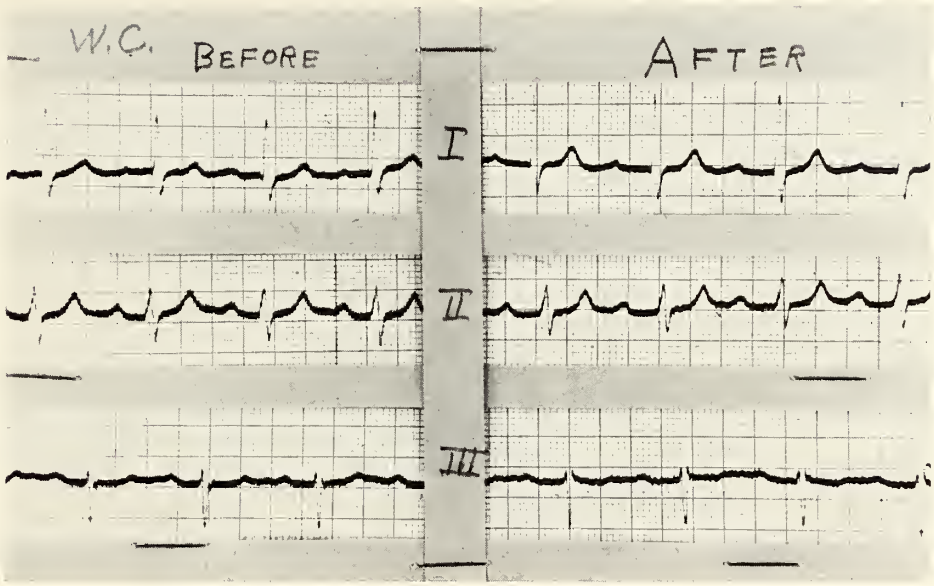


Figure II



peutic class C) was given 4 mgm/kg. of intravenous procaine, every other day, for four treatments. Her P-R interval was 0.20 second before the first infusion (illustration I). It increased to 0.23 second after the second, to 0.24 second after the third and to 0.26 second after the fourth. Treatment was discontinued; and three days later 24 hour serial electrocardiograms revealed a gradual return of her P-R interval to 0.23 second. She left the clinic at this time and further studies could not be made. She experienced no increase in cardiac complaints.

C. G., a white female, age 69, suffering from hypertrophic arthritis and an old fracture of the right hip, had a P-R interval of 0.20 second before the first infusion. After the third infusion the P-R interval was 0.26 second. Two more infusions were given cautiously the following week, with the P-R interval remaining 0.26 second.

W. C., a white male, age forty, had acute rheumatic fever. His P-R interval on admission to the hospital was 0.24 second. Three weeks later it was 0.22 second (illustration II). Because of persistent severe joint pains, he was given 0.1 percent procaine, 4 mgm/kg., intravenously. The ECG immediately following revealed a P-R interval of 0.28 second. Four days later the P-R interval had returned to 0.24 second. He has since made a full recovery.

G. M., a fifty-two-year-old, white male, with the diagnosis of multiple sclerosis and severe intercostal neuritis, had a P-R interval of 0.20 second prior to the first infusion. Following it the P-R interval was 0.22 second. Three more infusions were given but no further increase was noted.

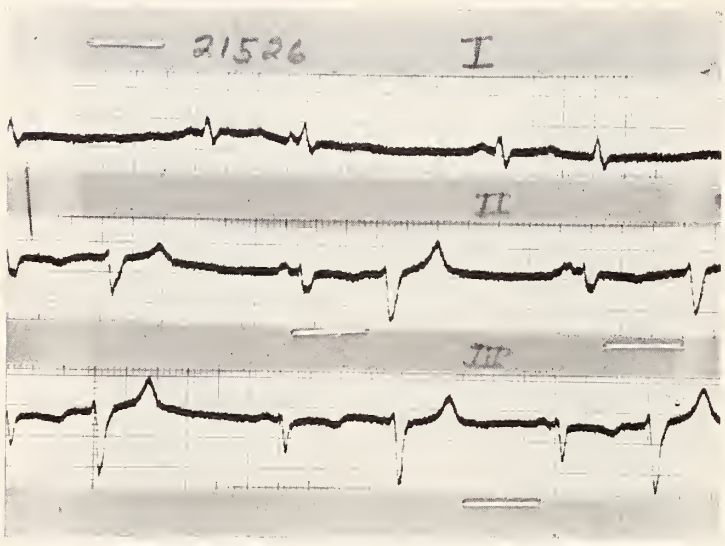
M. B., a sixty-eight-year-old, white female with combined arthritis, had a P-R interval of 0.18 second prior to the initial infusion. This was prolonged to 0.21 second following the first intravenous. Prior to the second infusion, twenty-four hours later, it was 0.19 second. She received seven infusions with changes after each, but the P-R interval never exceeded 0.21 second.

No cases of QRS interval prolongation were noted.

In addition to his arthritis, one patient presented arteriosclerotic heart disease, with an incomplete right bundle branch block and pulsus bigeminus due to premature ventricular contractions. The electrocardiogram (illustration III) showed a QRS interval of 0.11 second in duration with a wide S 1, and typical broad, slurred R-V 1 (not illustrated). Every second beat was a premature ventricular contraction. He received five infusions in seven days and no increase in the QRS conduction time was noted. The premature ventricular contractions, however, became intermittent after the first procaine infusion. After the third infusion none were noted in the entire tracing (illustration IV). Three weeks later the patient was seen and his rhythm had reverted to pulsus bigeminus. One infusion was given which returned the rhythm to a normal sinus mechanism. This case illustrates the effect of procaine on ventricular arrhythmias, and corresponds with the work of Rosenburg, et al.[16]

In contrast to the action on ventricular arrhythmias, the effect of procaine on supraventricular arrhythmias has been shown to be minimal by Rovenstine.[17] One of our cases, J. H., a fifty-one-year-old male, had auricular fibrillation for several years secondary to congenital heart disease. He

Figure III



was given four infusions for hypertrophic arthritis with no change in the rhythm.

Definite changes in the P waves were noted in four cases; also, all four showed changes in the QRS-T portions on the ECG.

Variation in the QRS voltage was a common finding. Nineteen of the forty-two cases revealed a significant change, seventeen showing a decrease and two an increase. Variation of voltage was considered significant when the total QRS voltage of the three standard leads was plus or minus 10 percent of the control tracing.

The amount of decrease of voltage varied widely, even in the same patient after successive infusions. Occasionally it was very marked.

H. G., a forty-eight-year-old white male, suffered from destructive arthritis of the right hip. His QRS voltage showed a marked drop after the fifth infusion from a control total Millivolts of 1.8 to 0.8 MV. (illustration V). Twenty-four hours later the total MV. had returned to 1.5.

T wave changes were seen in nearly half the cases, sixteen showing a decrease in voltage and eight an increase. There was marked variation similar to that seen in the QRS complexes. A variation of over 33 percent in T wave voltage was considered significant.

The QRS and T wave changes seen so frequently are undoubtedly a direct effect on the myocardium. This apparently occurs before the conduction tissue is affected. While marked decreases in QRS and T wave voltages were seen, no circulatory embarrassment was noted. The prolongation of the conduction time is more serious and could lead to cardiac standstill when it occurs with concurrent myocardial depression.

Our results confirm the impression that procaine is a powerful depressant of the heart. It is our opinion that patients with degenerative or inflammatory heart disease should receive procaine only after careful study, including electrocardiograms, before and during treatment.

SUMMARY

A study of the effects of intravenously administered procaine is presented. Forty-two patients, receiving two hundred and sixty-three procaine infusions, were studied. Control electrocardiograms were made before treatment was begun. Two hundred and fifty-seven ECG's were made and analyzed.

Analysis of the electrocardiograms revealed 1) P wave alterations (4 cases); 2) P-R interval prolongation (5 cases); 3) QRS voltage decrease (17 cases); 4) QRS voltage increase (2 cases); 5) T wave voltage decrease (16 cases); 6) T wave voltage increase (8 cases). Twelve cases showed no change following repeated infusions. Thirteen cases showed one change, and seventeen cases showed two or more changes. Two cases presented marked increase in the P-R interval necessitating cessation of treatment.

Two dosage schedules were used. Thirteen cases received 4 mgm. of procaine per kilogram in 20 minutes and twenty-nine received one gram of 0.1 percent procaine in one hour. The incidence of

Figure IV

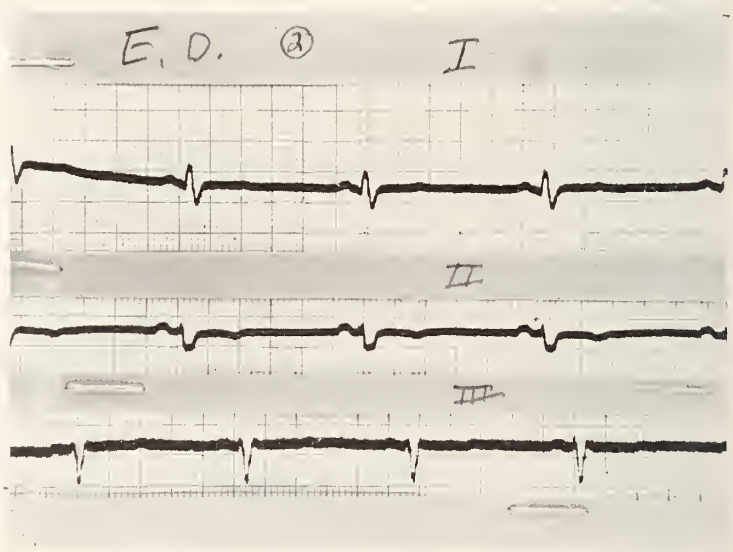
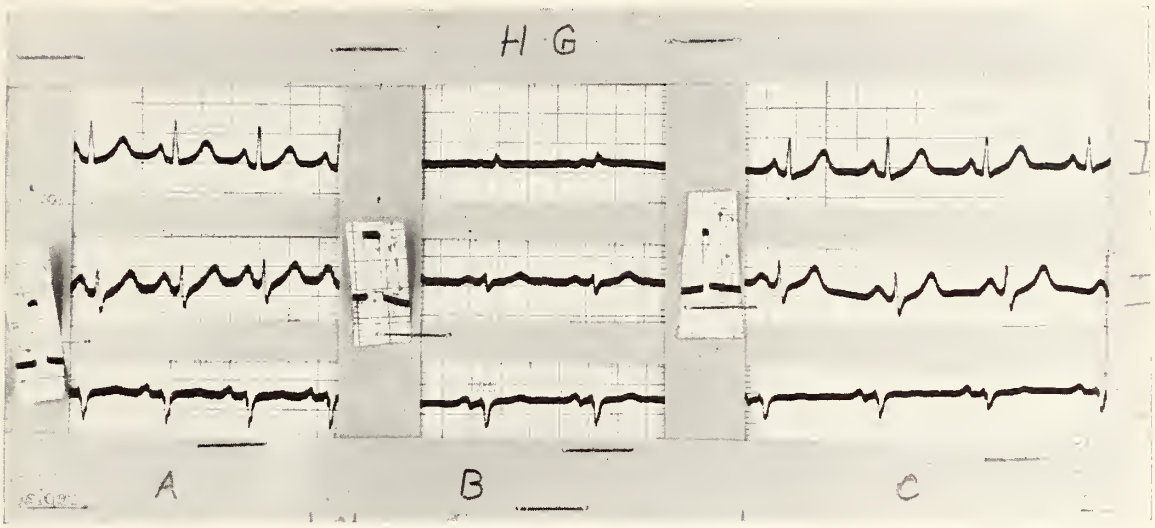


Figure V



ECG changes was slightly higher in the group receiving 4 mgm. per kilogram. Here ten cases (77 percent) contrasted with twenty (71.5 percent) in the other group had one or more changes.

The duration of the changes produced by intravenous procaine was variable and could not be correlated with the extent of the changes. In general the changes were gone in twenty-four hours, but several cases had changes persisting longer than three days.

CONCLUSIONS

(1) Intravenously administered procaine is a powerful depressant of the heart.

(2) It appears to have a depressant action on both the myocardium and the conduction system.

(3) This depressant action is beneficial in ventricular arrhythmias but is not evident in auricular arrhythmias.

(4) Procaine intravenously should be administered with caution in persons having heart disease; electrocardiograms should be made before and during treatment.

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SURGICAL TREATMENT OF HYPERTHYROIDISM*

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ONCE a diagnosis of hyperthyroidism is made, there is often confusion about its management and treatment. The hesitancy of medical men to recommend a plan of procedure is understandable in view of claims and counterclaims in our journals of cure by various agents: iodine, x-ray, radioactive iodine, and thiourea derivatives. This paper is an attempt to dispel the uncertainty surrounding the course to pursue. It is based on my experience with thyroidectomy in 300 consecutive, unselected cases of hyperthyroidism.

Sufficient time has elapsed for an impartial and working appraisal of the antithyroid agents. Clinical experience over a period of years has eliminated iodine and x-ray as curative agents. The use of radioactive iodine shows that at least 8,000 roentgens are necessary to produce remission in a moderately enlarged and toxic goiter. This amount of external irradiation with x-ray cannot be used without damage to the skin.

While radioactive iodine will destroy both normal and diseased thyroid gland tissue under favorable conditions, the immediate and potential sequelae are not known. Is it carcinogenic? Does it affect the reproductive cells in such a way that offspring might be heir to morphological and physiological abnormalities? The answers are in the affirmative in the experimental animal. In man, however, the answers are not yet clearly established; and for this reason the use of radioactive iodine should be limited to research.

Thiourea derivatives will lower the metabolic rate to any level, with few exceptions. These derivatives, unlike radioactive iodine, do not destroy the gland but produce remission by blocking the synthesis of thyroid hormone. The time required to obtain the euthyroid state varies from one month to two years. The average daily dose of the currently popular propyl thiouracil is 400 mg. As much as 1,000 mg. daily may be required in diffuse goiter with exophthalmos before there is a decline in the metabolic rate. Eight hundred milligrams daily has frequently been administered. Hyperthyroidism returns when the drugs are discontinued. These limitations preclude their use as a cure for thyrotoxicosis. However, they do have a place in the preparation of the patient for surgical treatment.

A definite program for the management of the thyrotoxic patient with antithyroid drugs was followed in this survey. Iodine is still the drug of choice for inducing remission. It reduces the metabolic rate three times faster than propyl thiouracil. It is without dangerous side reactions. Propyl thiouracil was employed in cases where iodine had failed. A new drug, 1-methyl-2-mercapto-imidazole, will soon be available. It is more rapid in its action and less toxic than propyl thiouracil. Thirty milligrams daily of 1-methyl-2-mercapto-imidazole was given to each of six patients not responding to iodine or propyl thiouracil. The average drop in the metabolic rate was two points per day. If this drop is substantiated by a larger number of cases this drug may replace propyl thiouracil.

The selection of definitive treatment completes the plan of procedure employed for a workable management and cure of hyperthyroidism; this is adequate subtotal thyroidectomy. Thyroidectomy is empirical but has stood the test of time. It is effective, economical and relatively safe; convallescence is short, requires a minimum of supervision, and there are few complications. My experience with thyroidectomy in this series of unselected cases of hyperthyroidism bears out these claims.

MATERIAL

Data used in this paper was obtained from records in the ten year period, January 1, 1940, to January 1, 1950, and is limited to my patients operated in the Methodist Hospital of Indianapolis. The age incidence is thirteen to seventy-three years. The average is forty-two years. Two hundred seventy-seven were women and twenty-three men, a ratio of twelve to one.

TYPE OF GOITER

This group consists of 121 diffuse and 179 nodular goiters. Thirty-seven of the diffuse goiters were complicated by exophthalmos of severe grade. Six of these were men. One of the six when first seen was in auricular fibrillation; there was dependent edema reaching the inguinal regions, with enlarged liver, ascites and fluid in the pleural cavities. The remaining thirty-one women with diffuse goiter included one in severe cardiac decompensation and with carcinoma of the left lobe. There were five recurrent cases in women, all of whom had been operated elsewhere; one had undergone three thyroidectomies.

Twenty-three solitary and 156 multinodular types comprised the nodular group. Seventeen were men, four of whom had solitary nodular goiters. Malignancy was not found in either sex. Cardiac

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decompensation, with attendant signs and symptoms, was present in eleven women. This complication was absent in the men.

MANAGEMENT

Management consisted chiefly of two phases: (1) Drug therapy while the patient remained on his job, and (2) A short hospital stay for final evaluation for surgery. Coexisting conditions and complications modified one or both phases of management. Iodine in the form of Lugols Solution, 15 M t.i.d. in grape juice, was given to all patients. Thiouracil, 0.2 gram four times daily, was given in the earlier cases and an average of 400 mg. of propyl thiouracil in the later cases, when iodine was found to be ineffective.

OPERATION

General anesthesia was employed in all cases. The anesthetist was permitted to select the anesthetic agents. In reviewing the records I find that cyclopropane or cyclopropane and ether was used almost exclusively. Tracheal intubation was reserved for cases that presented obstruction or when obstruction to the airway was anticipated in the removal of the gland. There were sixteen such cases.

The prethyroid muscles were rarely divided. The isthmus and pyramidal lobe were removed, as were major portions of both lobes. Routine visualization of the recurrent laryngeal nerves was not practiced. Care was exercised to spare the sites of the parathyroid bodies and the stumps were sutured to the trachea.

The gross pathology encountered tended to determine the size of stumps. The amount of gland removed varied from 10 grams to 799 grams. The total weight of both stumps remaining was approximately 1 gram in children and young adults with diffuse goiter and exophthalmos. Two or more grams were permitted in adults. Complete lobectomy was the rule for solitary nodular glands. Silk and cotton without drainage was used in 279 cases, catgut with drainage in twenty-one cases.

POSTSURGICAL COMPLICATIONS

Hemorrhage, immediate or late, obstruction to the airway, parathyroid tetany, permanent injury to the recurrent laryngeal nerves and crises were not encountered. There were five cases of temporary unilateral nerve paralysis, eight cases of temporary hypothyroidism, one recurrent hyperthyroidism, and two infections with wound dehiscence.

The recurrent laryngeal nerve recovered its function in seven to ten days. Two to six months were required for spontaneous relief of hypothyroidism. A man with diffuse goiter and exophthalmos returned with enlarged stumps and hyperthyroidism three years after radical subtotal thyroidectomy. He is presently controlled with 150 mg. of propyl thiouracil daily and will return for further surgery.

The first case of infection with wound dehiscence occurred twenty-four hours after surgery. A search failed to reveal the source of contamination. Two months were required for healing. The second case occurred seven days postoperative, following simultaneous removal of a right branchial cleft sinus. The source of infection was the sinus. This wound healed in one month.

SUMMARY

Iodine and propyl thiouracil at the present time are the most useful antithyroid agents for the reduction of hypermetabolism. In the near future 1-methyl-2-mercapto-imidazole may replace propyl thiouracil. These antithyroid drugs should be used only for the preparation of the thyrotoxic patient for surgical treatment. Subtotal thyroidectomy remains the best treatment for the cure of hyperthyroidism.

There was one death in this series, due to cardiac failure, and one recurrence; in all other cases a clinical cure was obtained and the patients resumed their normal life six weeks after operation. There was no other untoward residue of permanent nature from postoperative complications.

The results of thyroidectomy in these 300 cases indicate that there should be no confusion about the course to pursue in hyperthyroidism.

CONCLUSIONS

1. Iodine is not a cure for hyperthyroidism.
2. X-ray cannot cure hyperthyroidism.
3. Radioactive iodine should be used only in research at present.
4. Thiourea derivatives are not curative.
5. Iodine and propyl thiouracil are useful in preparing toxic goiters for surgery.
6. 1-methyl-2-mercapto-imidazole will reduce the metabolic rate when propyl thiouracil has failed.
7. Adequate subtotal thyroidectomy is the proper treatment for hyperthyroidism.
8. An analysis of thyroidectomy in 300 consecutive, unselected cases of hyperthyroidism shows:

a. Postoperative hemorrhage	0.0%
b. Parathyroid tetany	0.0%
c. Permanent injury to recurrent nerves	0.0%
d. Thyroid crises	0.0%
e. Permanent hypothyroidism	0.0%
f. Recurrent hyperthyroidism	0.3%
g. Wound infections	0.6%
h. Malignancy	0.3%
i. Mortality	0.3%
j. Clinical cure	99.1%

219 N. Pennsylvania Street.

ARE THE SHOE FITTING FLUOROSCOPES A HEALTH HAZARD TO THE PUBLIC IN INDIANA?

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During the last fifteen to twenty years the use of shoe fitting fluoroscopes has increased greatly. At the present time there are at least four different companies manufacturing fluoroscopes for this purpose. The machines consist essentially of a small x-ray tube operating at 50,000 volts and up to 10 milliamperes, an aluminum filter, and a fluorescent screen. These fundamental units are housed in various types of cabinets, the cost varying from $500 to $1,000, depending upon the style and finish of the cabinets. They may be equipped with automatic cutoff timers, interlocking switches, or three button switches which give different direct beam strengths used for fitting men, women, and children.

During the last five years a large number of articles in both the lay and scientific journals have discussed the possible hazards from the indiscriminate use of these machines. As an example of these articles *The Journal of the American Medical Association* carried an editorial[1] which concluded that the use of x-rays by untrained personnel cannot be made safe. Along this same line, Dr. G. Failla, Director of the Radiological Research Laboratory of the American College of Physicians and Surgeons, is quoted in the Monthly Newsletter of the American College of Radiology[2] as follows:

> "The thing to worry about is the possible injury to the growing foot in children and skin changes in adults which may cause cancer many years later, in spite of the fact that no erythema was produced at any time. It is these later changes that make x-rays particularly dangerous.
>
> "It has been said in connection with these machines that there is no evidence that damage has been caused through their use. This does not mean that no damage will manifest itself later. Short of a severe x-ray burn, any other change would readily be attributed to other causes by those not familiar with the biological effects of x-rays."

To emphasize clearly the possible damage, Hemplemann[3] cites several potential biological effects of such exposures and concludes that the type of damage most likely to occur is the malformation of the feet of growing children. He further states that the x-ray dosage which may cause damage to the epiphyseal cartilage may be only about one-half of the erythema dose for children.

Several articles covering both sides of the question have been published in the lay press and the shoe retailer's association journals. Perhaps the most outspoken article[4] was published in *Consumer Reports* for April, 1950, with the following conclusions:

> "In the light of these hazards, consumers should resist salesmanship involving a fluoroscope machine and stay yards away from such a machine when they are in a shoe store.
>
> "There might be some logic in risking dangers, if there were any reason for the employment of a fluoroscope in fitting shoes. Almost all orthopedic specialists are agreed that there is no such reason. Peering at the bones of the feet by fluoroscope may be colorful tactic of salesmanship but is technology misused and usually misinterpreted."

One of the first technical societies to take notice of the problem was the American Conference of Governmental Industrial Hygienists, which passed a resolution[5] at their 1949 meeting strongly condemning the use of these machines and urging all official agencies to work toward the control of this hazard. At the 1950 meeting of this society a suggested code was presented which it was hoped would at least reduce the x-ray hazard.

INSPECTION OF FLUOROSCOPES

To determine if such a hazard actually existed in Indiana, a pilot survey of the shoe fluoroscopes was made in Indianapolis in late 1949 and early 1950. Studies were made of the direct x-ray beam strength, scatter radiation from all sides of the machine, from the viewing ports, and from the shoe ports, exposure time, and the various controls on the machine. During the initial survey seventeen machines were checked in thirteen stores. Later three machines recently purchased were checked in three other stores. The age of the machines varied from thirty years to two months. Eleven of the twenty units had automatic cutoff switches to limit the exposure time.

The direct beam strength varied from three to seventy roentgens per minute, while the scatter radiation from the shoe ports exceeded 1,200 milliroentgens per hour in all cases, and in a majority were far in excess of 2,000 milliroentgens per hour. Radiation from the viewing ports ranged from 1.0 to 1,400 milliroentgens per hour.

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TABLE 1

Summary of Survey Data
Fluoroscopic Shoe Fitting Machines
Located in Indianapolis

No.	Item	Minimum	Maximum	Average	Median
1.	Exposure time (if timer on machine) sec.	5	33	19.6	19.5
2.	Operating current milliamperes	1.6	5.2	3.9	3.9
3.	Direct X-ray beam—right foot r/min.	5.0	62.4	22.6	18.6
4.	Direct X-ray beam—left foot r/min.	3.0	69.9	24.3	20.0
5.	Scatter radiation from shoe port—mr/hr.	1200	THM*	-----	-----
6.	Radiation at viewing ports				
	a. Right—mr/hr.	1.0	1140	111.4	10.0
	b. Left—mr/hr.	1.2	1280	118.7	12.0
	c. Customer—mr/hr.	1.5	1200	99.8	14.0
7.	Scatter radiation—operator's side of machine				
	a. Measured at machine—mr/hr.	0.6	2000	103.2	16.0
	b. Measured 5 ft. from machine—mr/hr.	0	320	29.3	4.7
	c. Measured 10 ft. from machine—mr/hr.	0	39	4.8	1.4
8.	Scatter radiation—right side of machine				
	a. Measured at machine—mr/hr.	4.0	2000	228.6	29.0
	b. Measured 5 ft. from machine mr/hr.	1.6	600	55.0	9.9
	c. Measured 10 ft. from machine—mr/hr.	0.8	190	26.6	2.9
9.	Scatter radiation—left side of machine				
	a. Measured at machine—mr/hr.	2.4	THM*	187.8	50.0
	b. Measured 5 ft. from machine mr/hr.	0	1200	113.3	13.5
	c. Measured 10 ft. from machine—mr/hr.	0	400	49.7	4.0
10.	Scatter radiation—front of machine				
	a. Measured at machine—mr/hr.	0.5	THM*	376.2	78.0
	b. Measured 5 ft. from machine—mr/hr.	45.0	1600	248.9	130
	c. Measured 10 ft. from machine—mr/hr.	1.6	480	70.7	28.0

*THM—offscale on Beckman MX2—in excess of 2000 mr/hr.

The minimum scatter radiation, measured six inches from the sides of the machine, was 0.6 milliroentgens per hour with a maximum in excess of 2,000 milliroentgens per hour. Even at a distance of ten feet from the machine the scatter radiation varied from 0 to 480 milliroentgens per hour. A complete summary of the data is given in Table 1.

Following the Indianapolis study, a request for a similar survey of the shoe fluoroscopes was received from the Vanderburgh City-County Health Department. This survey covered eleven machines located in nine Evansville stores. The results found were almost identical with those previously found, except that one machine was found with a direct beam strength of 100 roentgens per minute.

As a result of the Indianapolis survey, one large chain store had all the machines in their Indiana stores returned to the manufacturer for adjustments and remodeling. It was interesting to note that when two of the remodeled units were checked in Evansville, they were found to be much safer than the general average of the machines.

TOLERANCE STANDARDS

To visualize the magnitude of the hazard, the comparison is made with the various standards now in effect. The American Standards Association[6] in 1946 stated that the tolerance dose of x-rays to the foot should not exceed two roentgens per exposure. This means that for a five second exposure the maximum beam strength should not exceed twenty-four roentgens per minute. Yet very few of the units studied had such beam strengths.

In regard to scatter radiation it should actually not exceed 6.25 milliroentgens per hour at the machine if it is to meet the standard allowable dose of 300 milliroentgens as set up by the U. S. Department of Commerce Advisory Committee on X-ray and Radium Protection. Practically none of the machines could meet this requirement.

In most of the stores surveyed, the machines were poorly located. Frequently waiting chairs were located close to and in a direct line with the shoe port, which resulted in anyone sitting in these chairs being sprayed with scattered x-rays. Also, frequently chairs would be placed directly against the side of the machine. In general, few operators had any knowledge of the dangerous machine they were using.

Similar extensive field studies have been done by Williams of the Harvard School of Public Health,[8] the Detroit Department of Health,[9] the Illinois Department of Health,[10] and the Massachusetts Department of Public Health.[11] The results obtained by these workers agree closely with those found in Indiana. Most of the machines studied were found to have too high a beam strength, excessive scatter radiation, and were poorly located. In an effort to reduce the hazards from the use of shoe fitting fluoroscopes, New York City,[12] and Detroit[13] have passed codes covering the machines. These two codes differ only slightly, the variance being that New York sets two roent-

gens as the maximum dosage while Detroit allows only one roentgen. New York sets the maximum number of exposures to three per day or twelve per year, compared to Detroit, which allows five fittings per day and a yearly total of twenty. Cleveland[14] has issued a manual for the use of repairmen in making repairs and adjustments on the units.

Recently, the U. S. Public Health Service,[15] the Missouri Department of Public Health and Welfare,[16] and the Texas State Department of Health,[17] while not reporting studies, have issued informational bulletins outlining the dangers and suggesting possible controls.

When the data found in this survey is studied and the literature is reviewed, it documents the fact that the shoe fluoroscopes in their present status are definitely a health hazard to the public in Indiana. In view of this, the Indiana State Board of Health is preparing a regulation which it hopes will greatly reduce the dangers of shoe fluoroscopy. The important points in this regulation are:

1. The maximum direct beam strength shall not exceed twelve roentgens per minute.
2. Scatter radiation measured at a distance of six inches from the machine shall not exceed 6.25 milliroentgens per hour.
3. Scatter radiation from the viewing ports shall be less than 6.25 milliroentgens per hour.
4. Scatter radiation from the shoe port must not be directed toward any occupied area and must not exceed 6.25 milliroentgens per hour at a distance of ten feet from the machine.
5. The maximum exposure time shall be five seconds with a daily total of not more than five fittings, a yearly total of not more than twenty-five fittings.
6. A warning placard stating that overexposure to x-rays is dangerous must be placed on all machines.

SUMMARY

A study of thirty-one shoe fitting fluoroscopes is reported along with a survey of the literature on this subject. The direct beam strengths varied from three to one hundred roentgens per minute, with scatter radiation at a distance of six inches from the cabinet varying from 0.6 to in excess of 2,000 milliroentgens per hour. Radiation from the viewing ports ranged from 1.0 to 1,400 milliroentgens per hour. Scatter radiation from the shoe ports varied from 1,200 to in excess of 2,000 milliroentgens per hour. It is concluded that a definite radiation hazard exists from these machines in their present status. A proposed regulation to reduce these hazards is outlined.

NOTE:—Since this paper was submitted for publication, the Indiana State Board of Health has adopted the regulation referred to.

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SHOULDER PINNING FOR NECK FRACTURES OF HUMERUS

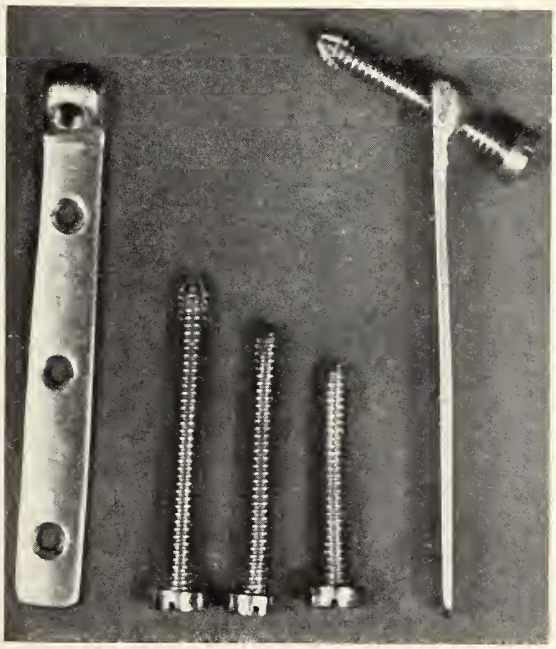
F. E. Hagie, M.D.

RICHMOND

THE CARE of fractures of the neck of the humerus has not run parellel with the care and interest in the pinning of similar fractures of the femur. The fact that the femur is a weight-bearing bone may account for our concentration on the pinning of hip fractures of recent years, and for our forgetting that we have a very similar condition in the shoulder.

In comparing the upper part of the femur and the humerus we find that we have a ball end of each bone entering a cavity, thus making a ball and socket joint with the femur into a deep cavity or joint and with the humerus into a shallow joint. The head of the femur has greater fixation due to the ligamentum teres; also, the capsular ligament in the case of the femur is much tighter than the capsular ligament in the shoulder. Mainly on account of this difference, some form of mechanical fixation to put and hold a very movable head after fracture in the right position on the shaft of the humerus is necessary. The angle the head and neck of the femur makes with the shaft of the femur is 120 degrees. The humerus has a very short anatomical neck, but the angle of the articular surface of the head of the humerus with the shaft is 120 degrees, the same as in the femur. Both bones have a thin cortical layer over the head and neck, with the center made up of a soft spongy type of bone.

Cut #1



I became interested in this type of fracture of the humerus after I put out my small lag screw pins for neck fractures of the femur in 1938,[1] and my shoulder plate and lag screw in the care of intertrochanteric fractures of the femur, which I put out in 1946.[2]

My mechanical device for the care of these neck fractures of the humerus has been patterned after my shoulder plate screw and lag screw, which I have used with such success in intertrochanteric fractures of the femur. Cut #1 shows the shoulder plate and lag screws which are made out of stainless steel of the 303 series, spoken of as the 18-8 stainless steel, referring to the percentage of chromium and nickel respectively in the alloy. This is the most noncorrosive of all the stainless steels, nonmagnetic and nonheat-treated. One plate in this cut has the lag screw in place or partially assembled. The plate has a shoulder at the end with a threaded channel for the lag screw at a 120 degree angle. The plate is 3 inches long, ⅜ inch wide and 1/16 inch thick, with three holes for screw fixation to the shaft of the humerus. With each plate I have made three lag screws of different lengths, 1¼ inches, 1½ inches and 1¾ inches,

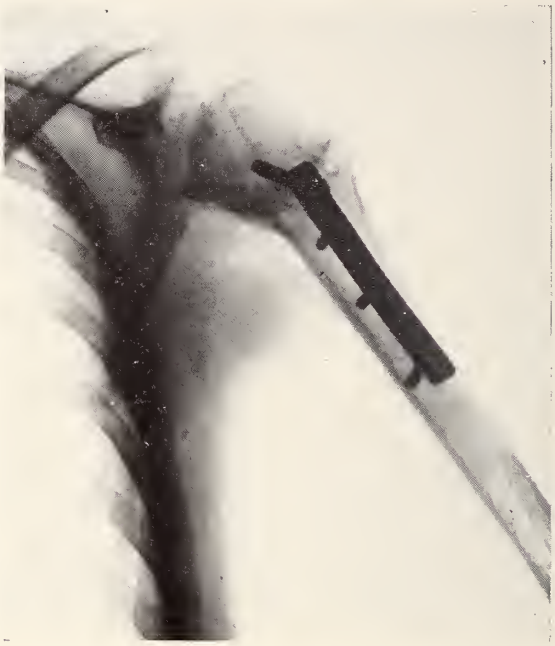
Cut #2



Cut #3



Cut #4



to take care of the different lengths that may be needed. The lag screws are 3/16 inch in diameter, threads 24 to the inch, with the ends sharpened and grooved for tap effect, and with the heads round and slotted for screw driver insertion. No special instruments are needed for the application and the procedure is done under better vision than we have in our care of hip fractures.

In the application an incision is made on the lateral surface of the arm below the acromion process, exposing through the deltoid muscle the shaft of the humerus. Reduction of the fracture is made by traction, manipulation and the forcing of the shaft out from the axilla, if need be. Reduction is held by forcing the forearm over the body. The plate is first attached to the shaft of the humerus by three screws. The position of the plate on the shaft is arranged according to the fracture line in reference to the head. The surface of the shaft for attachment of the plate is lateral to the intertubercular groove which lodges the long head of the biceps, and is below the greater tubercle. This surface of the humerus, which is more or less of a negative area, is very adaptable for plate attachment. In order to start the lag screw through the cortex, I use a #25 wire gauge drill through the lag screw channel in the plate, drilling through the cortex of the bone. The lag screw is then applied to the plate, lagging into the head with the screw driver. I have used a 1½ inch lag screw in the pictures shown. After the application, fixation can be tested under direct vision. I also check by x-ray during the procedure.

An anteroposterior view of a neck fracture of the humerus is shown in Cut #2, showing the head rotated downward and below the glenoid fossa due to the normally loose capsular ligament, and with the shaft posterior to the head. Cut #3, taken at the time of operation, shows the plate and lag screw being applied. Cut #4 is the final picture a few weeks later, showing perfect reduction, with some callous formation.

With a hanging joint of this type and with the above fixation, a sling is all that is necessary in the after-treatment. I feel that a mechanical device for fixation in this type of fracture, where the proximal part is made up of a soft spongy type of bone, must have a firm fixation between the shoulder plate and lag screw to hold the angle. For that reason I adopted my mechanical device for intertrochanteric femur fractures and have applied this same principle to hold the humerus neck fractures.

Any type of treatment, no matter how negative, for these fractures will give normal forearm activity but the real test of a good result is to have the patient able to put his arm up so that the elbow is above the level of the shoulder. This can be accomplished only by putting the shaft on the head in its proper place and with fixation while healing. The patient with the shoulder injury as shown in the above picture is 66 years of age and has full use of her arm following the above care.

I do not advise pinning all neck fractures of the humerus, but those with the end of the shaft driven into the axilla and those that cannot properly be reduced should be opened and have internal reduction and fixation. The results will more than warrant the procedure.

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CLINICAL MANAGEMENT OF PEPTIC ULCERS IN GENERAL PRACTICE

Otis R. Bowen, M.D.

BREMEN

THE MANAGEMENT of patients with peptic ulcer in general practice is very difficult. It is difficult to get cooperation from the patient unless he is treated on a completely ambulatory basis. It cannot be done on an ambulatory basis unless the treatment is easily accomplished and adapted to the majority of the people in the typical general practice area regardless of sex, occupation, or age. I have tried to simplify the treatment without reducing effectiveness. The treatment outlined can be carried on with a minimum of bother and expense during any type of work or vacation, including all day driving.

It is necessary to have complete control of the patient to effect a cure in reasonable time. It is for this reason that I feel it advisable to see the patient every two weeks and dispense all medicine required in the treatment. If this is not done and a prescription is written, the patient will obtain whatever medicine is needed at the pharmacy and continue taking it indefinitely—many times failing to return for further therapy and regular evaluation of his treatment. When he feels a little better he will alter his diet and medication to suit himself; oftentimes this is detrimental to his incompletely healed ulcer.

The treatment must accomplish the following things: (1) decreased secretory action, (2) decreased gastric motility, (3) decreased nervous tension, (4) supply an adequate and balanced diet which is unobtainable in the early phase of any ulcer therapy unless the diet is fortified with nutrient powders containing proteins, carbohydrates, and vitamins.

A routine that has proved successful in a series of seventeen peptic ulcer patients (nine duodenal, seven gastric and one both), which were proved by x-ray before therapy, is presented. Numerous others with clinical findings of ulcer, who chose not to have x-rays, were likewise relieved of their symptoms. Eleven of these seventeen were proved healed by x-ray after therapy and the other six were clinically healed, but for economic or other reasons failed to obtain their second x-ray. One case was a post-perforation; one a combined double gastric and duodenal ulcer; and one a huge gastric ulcer on the greater curvature of the stomach, reported as a probable malignancy, that was given two weeks ulcer therapy and re-x-rayed and the lesion was healed. A third x-ray (taken six weeks after the reporting of the original and four weeks after the reporting of the healing of the ulcer) was taken and the lesion was still healed. All x-rays were taken and reported by reputable board members in the field of roentgenology. One case not included in the above had ulcers for many years, had lost weight down to 120 pounds and was subsisting on a small amount of milk alone, and even then was having considerable pain over his entire abdomen. He was given the same formula as ulcer patients for two weeks to help build him up and get him ready for gastric resection. Conclusions of his x-ray report were as follows: "(1) Filling defect and ulceration of the mid-portion of the stomach, in all probability representing a carcinoma. There appears to be infiltration along the lesser curvature of the cardia. (2) Ulcer of the prepyloric region of the stomach." He gained four pounds the first week and was stronger and felt free of pain for the first time in many months. Surgery, two weeks after the original x-rays, revealed the presence of only the large gastric ulcer, which proved to be benign. His post-surgical diet was started exactly as we start routine peptic ulcer diets. He is now gainfully employed and mentally and physically a healthy man, five months after his surgery.

Our routine in the treatment of peptic ulcers consists of the following: (1) Six feedings per day. (2) One teaspoonful of *neutragel after each feeding. (3) Milk of magnesia, alternated with neutragel, in equal amounts as often as necessary in order to provide for adequate bowel movements. (4) *A capsule containing ¼ grain Nembutal and 1/6 grain of belladonna, given before every other feeding. (5) Advised to reduce or abstain from smoking. (6) Get more rest physically, mentally, and emotionally.

The first two weeks of the feeding consists of the following recipe, each of which supplies approximately 450 calories:

1 cup of chilled milk
1 egg
dash of salt
1 tablespoon or less of sugar
½ teaspoon of *Homicebrin
4 heaping tablespoons of *Delmor or *Delcos (whichever suits the taste of the individual better)

To this may be added for flavoring a small amount of vanilla, nutmeg, chocolate syrup, maple syrup, fruit flavoring or ice cream. The patient is instructed to mix enough formula to last a day. He may take the proper amount in a thermos bottle to work with him and take feedings at the required hour. The feedings are taken

in the morning, mid-morning, noon, mid-afternoon, evening and bedtime. He is instructed that if he awakes in the middle of the night with any hunger or distress that he may take an additional feeding. The feedings may also be served hot; if this is done the Homicebrin should be added after the heating. At the end of two weeks, providing a satisfactory response has been obtained, other foods are gradually added. A satisfactory response should include the following: absence of nausea, vomiting and epigastric pain; diminution of epigastric tenderness and bloating; bowel regularity; moderate satisfaction of appetite; and weight maintenance or at least a shift of no more than two or three pounds.

The first food additions are usually cooked cereals, toast without the crust, poached or soft-boiled eggs, jello, custard or cottage cheese. He is instructed to take these in addition to the six feedings mentioned above. He is told that he is not to go hungry. Every two weeks, providing his condition remains satisfactory, other bland types of foods are added until at the end of three months he is on a full, low-residue, bland diet. At this time another x-ray is taken to evaluate treatment.

In every case but one there was complete healing of the ulcer. In this one case the cooperation of the patient was very unsatisfactory, inasmuch as he was a mint farmer and persisted in working 16 to 18 hours a day in the mint field, did not carry his diet with him, and was very lax about taking capsules and Neutragel. The second three months trial treatment, following a lecture on the necessity of his cooperation, brought about a healing of his ulcer.

It is gratifying to note that in practically every case soreness and pain were nearly totally gone after three to four days on the formula. Weight was maintained and a feeling of well-being was obtained rapidly.

After the ulcer is healed the patient is advised to remain on a bland, low-residue diet indefinitely and is advised to get another x-ray in six months. Those who have complied with this request have remained healed.

The Delmor eggnog preparation is also useful in treating the aged, malnourished, and as a dietary supplement for severe burns, pregnancy, and in convalescence from debilitating diseases and surgical procedures.

SUMMARY

Therapeutic problems concerning peptic ulcers in general practice are discussed and a successful method of ambulatory treatment of the routine peptic ulcer case is presented.

* Neutragel is a brand of Aluminum Hydroxide Gel USP made by Fidelity Medical Supply Company. Nembutal and belladonna capsules No. 2 are made by Abbott Laboratories. Homicebrin is a liquid multiple vitamin compound made by Eli Lilly and Company. Delmor and Delcos are nutrient powder and nutrient granules made by Sharp and Dohme.

AUREOMYCIN USED TO PREVENT TOOTH EXTRACTION INFECTIONS

Successful use of aureomycin in reducing bacterial invasion of the blood as a result of tooth extraction is reported by a group of doctors and medical researchers at the Hospital of St. Raphael, New Haven, Conn. This is of particular importance to patients with heart conditions.

Writing in the October issue of *Archives of Internal Medicine,* the doctors report "twenty percent of all cases of subacute bacterial endocarditis can be traced to recent dental manipulation."

Drs. Oscar Roth and Robert H. Parrott; A. L. Cavallaro, oral surgeon; and Rose Celentano, medical technologist, made a study of 50 patients. Half the patients received aureomycin; the other 25 remained untreated. Blood tests revealed streptococcus viridans (the organism most commonly implicated as causing the membrane infection) in 14 of the untreated patients but in only one of the patients who received the drug.

Streptococcus viridans is present in the mouth of healthy persons but increases in number with gum infections and dental decay. Defenses of the body ordinarily would destroy the bacteria. However, if the heart membranes have been injured by previous illnesses or disease, often unknown to the patient, the bacteria implant themselves on the damaged tissues.

"For this reason, it is of the utmost importance to eliminate the source of infection in persons with heart disease.

"Particular caution is necessary in these patients prior to tooth extraction or any other dental manipulation, especially when infection is present, in an effort to reduce the high incidence of transient bacteremia following such operations."

Every patient before a tooth extraction should be carefully questioned and examined for certain heart conditions. If such a condition is found treatment should be given to reduce the bacteria, the report advises.

In the opinion of the doctors making the study, aureomycin was given good recommendation because it can be given orally, it apparently does not produce drug-resistant organisms, and it successfully reduces streptococcus viridans.

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MENTAL HEALTH WEEK MAY 2-8

ONE out of ten persons in this country is in need of treatment for some emotional or mental disorder. One out of twenty will spend part of his life in a mental institution. America could well afford to make every week mental health week. This would help us to recognize one of our most important health problems.

To focus attention on the work that is being done to improve mental health in Indiana, and on the work that needs to be done, the Indiana State Board of Health, the Indiana Council for Mental Health, and the Indiana Mental Hygiene Society are cooperating with the medical profession in preparing the Mental Health Week program.

Bettering the mental health of our state is a challenge that we can meet by working together, by research, by obtaining trained personnel, and by understanding the problems of those suffering mental ill health.

PENICILLIN REACTIONS

RECENT increases in the number and severity of penicillin reactions have raised the question as to whether the drug has been used too indiscriminately. Opinions are being expressed to the effect that the exhibition of penicillin for trivial or non-existent indications may be sensitizing patients who may later need the antibiotic for a serious infection, and who, because of their acquired sensitivity, may be deprived of its benefits when they are really in need.

As the use of penicillin has increased by leaps and bounds, the reports of serious and fatal reactions to the drug have become more and more frequent.

Originally there were a few patients who developed symptoms of primary sensitivity. However, recently, the cases are more of the acquired or anaphylactic type, and many of these must be due to a previous experience with the agent.

The seriousness of the acquired type of sensi-

tivity, with its generalized exfoliating lesions, anuria, and rapidly fatal reactions, is sufficient to warrant some thought as to ways and means of reducing the incidence of such trouble. Very often the acquired sensitivity is recognized, only after the fatal dose of the drug has been given. The only protection against such catastrophes is to avoid the primary sensitization.

It is now generally recognized that the use of penicillin topically, as in ointments, or its administration by the oral route, are the methods which are most apt to result in sensitization. It is not difficult to avoid these usages now, since the long-acting preparations of the drug for intramuscular injection may be substituted.

As a corollary to the rule of avoiding the topical use of penicillin in an ointment, physicians and nurses might well take heed of the hazards of handling the drug; and should make it a rule to cleanse their hands carefully after preparing doses for injection.

Only recently a nurse suffered a fatal reaction when she administered treatment to herself in the form of an intramuscular dose of penicillin. The lesion which she was treating was described as a reddening and swelling of the eyelids, evidently a local indication of her sensitivity resulting from accidental topical application of the drug.

Reducing the prophylactic and routine use of penicillin would also, no doubt, tend to lessen the dangers of reactions. It is difficult to rationalize the use of antibiotics in what are usually clean surgical cases, when the patient is progressing satisfactorily, in order to avoid some infectious type of complication which almost never occurs.

When one considers the widespread and indiscriminate application of the "wonder drug," it appears that the wonder is that it has not produced more unfavorable responses. Certainly it is the better part of wisdom at the present time to utilize penicillin in a prophylactic way only when the complication to be avoided is a serious one and one which occurs frequently in the absence of precautions.

Other safety rules which are recommended in regard to reactions, which are now more numerous and serious, would be to watch each patient who is receiving the drug very carefully for untoward behavior, and to question each patient concerning known penicillin sensitivity and other allergic phenomena before treatment is started.

CASE REPORTS

CASE REPORTS were once the foundation of clinical medical literature. They have appeared less frequently during recent years. However, when well written they are still the most interesting and most informative of all the various types of medical writing.

Although set aside in popularity by the more ponderous and exhaustive treatises, case reporting should be revived for the good of medical literature. It is a form of writing by which every doctor may express himself. It requires only a well cared for and accurately recorded case; it does not necessitate a research project, a large library, or the review of a large number of cases.

Very often the busy reader will profit most from a practical case report, and what is more important will be able to read it because it is short and to the point.

Case reports may suffer from the same faults as do other forms of medical writing—but when carefully composed, when written in concise style, they possess advantages not allowed the other forms.

A case report to be interesting should have as its subject a case which is unusual—as to incidence, or in regard to the treatment employed or results obtained.

The report should preferably be introduced by a statement to indicate why the author considers the case as worthy of a published report.

After the introduction, the history and progress of the patient should be concisely stated. It is this portion of the paper that determines whether the communication as a whole will be read and enjoyed. Good case reports contain all the relevant clinical facts, and eliminate all the irrelevant findings. All negative and unimportant details should be ruthlessly weeded out. If this is done the result is a short and interesting account which all doctors will read and enjoy, and from which all may learn a lesson.

The manuscript should be broken into short paragraphs, many of which may well have subheadings, such as history, physical examination, course, and if applicable, post-mortem observations.

Most of the clinical laboratory reports should not be copied verbatim, but should be condensed, and stated in the author's own style.

While brevity is a virtue, it should not be obtained by the use of abbreviations which are often the products of local usage, and may be unintelligible to others.

A brief discussion provides a suitable ending. This should usually be limited to the one clinical point upon which the report is based.

The staff of THE JOURNAL is interested in encouraging the writing of good case reports, and invites the submission of this form of medical literature by all its readers.

STUDENT AMERICAN MEDICAL ASSOCIATION

"THE NAME of this association shall be the Student American Medical Association.

"The objects of this association shall be to advance the profession of medicine, to contribute to the welfare and education of medical students, to familiarize its members with the purposes and ideals of organized medicine, and to prepare its members to meet the social, moral, and ethical obligations of the profession of medicine."

The above quotation from Article I of the Constitution of the SAMA specifies the purpose of the organization. Student representatives from forty-seven medical schools in the United States met in Chicago in December, 1950 and laid the foundation for their own medical society. A constitution was adopted providing for a House of Delegates and an Executive Council, and a democratic system of government.

The Association is composed of academic societies, located in approved medical schools, with membership drawn from the student body. Each constituent society will be known as a student medical society.

The planning for this accomplishment was carried out under the auspices of the Board of Trustees of the AMA. It has been felt for some time that an organization such as this was needed to acquaint medical students with the responsibilities of medical practice. Proper liaison with the school and with the regular medical societies will provide ample opportunity for the fulfillment of the objects of the association.

The students of Indiana University School of Medicine are now in the process of organization. Some two hundred students have signified their intention to join. Richard Snapp represented the school at the Chicago meeting and Roland B. Rust, as temporary chairman, and Emmett Pierce, as temporary secretary, are in charge of the preliminary planning.

Each student medical society will have an Advisory Committee, which will include, in addition to three faculty representatives, a county medical society representative and a state medical society representative.

Dr. Cleon Nafe has been seleced to represent the Indiana State Medical Association on this committee, and Dr. J. O. Ritchey will represent the Indianapolis Medical Society.

Dr. George F. Lull, in his address of welcome to the constitutional convention, pointed out that there are many activities of organized medicine which are not commonly known, even by some doctors, and that medical students will profit greatly by having the advantages of contacts with the active profession.

One of the innovations of the SAMA is that it will choose two of its members as representatives to the AMA House of Delegates, to attend all sessions, to make reports as requested, and of course to report to the student association on the doings of the AMA.

Many valuable experiences and much useful knowledge, all of which is an integral part of a medical education, but which cannot be taught in medical school, will accrue to the advantage of future doctors, by the function of this new medical society.

SOCIALISM TRIES THE BACK DOOR

That concern about nursing education and its repercussions on medical practice is spreading to many parts of the country was shown in an editorial in a previous issue of this JOURNAL. From the South comes the following, in the *New Orleans Medical and Surgical Journal:*

> Another such bill, in which one segment of the State medicine scheme is being advocated, is H.R. 910, introduced on January 4 by Representative Frances P. Bolton. The bill is designed to give financial assistance to nursing schools; to provide scholarships to qualified students, seeking career nursing; to provide for research in nursing; and to provide for recruitment of nurses. No stated amount is appropriated to meet these ends. The specific amount of $5,000,000 is authorized for the fiscal year ending June 30, 1952, and for each succeeding fiscal year, for the construction and equipment of new schools of nursing and the expansion of existing facilities. The effect of the bill would probably be to increase the number of prospective students in the field of postgraduate nursing.
>
> If enacted into law, this bill would add greatly to the expanding power of the Federal Security Administrator, Oscar R. Ewing, as it would be administered by him. There is a provision for a national council of nursing education. The function of the council is to give advice and recommendations, but the council has no final authority. This would rest, as in most such bills, with Mr. Ewing. Following the provisions of this sort, it is quite easy to see that the Administrator could, by favoring one type of school and restricting another, very easily acquire complete domination over the whole field of nursing education. A private nursing school in a private hospital could hardly compete with the largesse flowing from the taxpayers' pockets through the schools subsidized by the federal government.

After reading this you may wish to write your Congressman. So far, there is no law against doing that.

President's Page

INDIVIDUAL RESPONSIBILITY

THE OTHER DAY, a man whose friendship I prize, said to me, "You know, I am an outsider to your profession but sometimes outsiders can see things which those on the inside might not appreciate. I know that you doctors have been receiving a lot of criticism recently. I doubt if you realize how much such talk goes on and how bitterly some people feel. You would be surprised at the many who complain of the enormous fees and the little help given. And you would be surprised at the many who say that it is the doctor himself who is throwing your profession into socialized medicine. Of course," he continued, "you and I know that doctors are busy, but just last night I heard a woman complain that 'it seems like my doctor has his hand on the door knob ready to let me out as I am walking in.' "

Yesterday another friend let himself go and said, "Too many doctors think they are better than anybody else and think they are in a privileged class all by themselves. I had to wait two hours and ten minutes in a doctor's office this week and that is just not good business. My time is as valuable as his time, and even with an appointment I had this long wait, and without any explanation. Doctors can't continue to get away with this. I patronize dentists and lawyers, too, and they are busy people, but they have time to treat me right."

It is pretty generally recognized that there has been a wave of commercialism spread over the world. Most people believe that the effects of communism, with its philosophy of materialism versus Christianity, has tainted and tarnished every segment of our society. From the many letters received in our headquarters office from various parts of the state, which express bitter complaint about the treatment the writers have received at the hands of certain doctors, we realize that some doctors, too, have fallen prey to unfortunate thinking. No doubt, there are doctors within our ranks who are our worst enemies. The evidence is too conclusive to believe otherwise.

Too many physicians have lost sight of the fact that the practice of medicine is not primarily a way to make a living but is a way of life. Since the beginning of our profession, civilization has looked to us with profound faith that we would render service to the sick and to the afflicted. Those doctors who have gone before us conducted themselves so that no personal service commanded greater public respect and esteem than ours. In this new day, however, while they have respect for the scientific achievements of our research men and scientists, the public no longer has this warm regard for our practitioners. Even a cursory investigation will convince anyone that a sizeable percentage of the public feels ill and sometimes bitter about the medical care they are receiving at the hands of some of our profession.

If anyone owes an obligation to posterity, if anyone should see to it that this cycle of materialism is reversed, it is the doctors. Because of our education, the nature of our daily work and the esteem which civilization has always held for us, we must realize that if physicians allow themselves to become ordinary, then to whom can we look to lead the way back? Civilization has a right to expect leadership and good things from us. We must appreciate that physicians have the God-given obligation, as well as opportunity, to lead the way to a return to the practice of the Golden Rule. If we fail in this it will be a sad day for humanity. Let each of us take inventory of himself and reconsecrate his life to the service of mankind. This is an individual responsibility.

Alfred Edison

Medical Panorama by the Associate Editor

Common Sense in Disaster Relief

Dr. Charles C. Lund, writing in *New York Medicine* for October 20, 1950, presents the following interesting and important paragraph:

Sedation should be used cautiously early after an atomic bomb explosion because the survival of many patients may depend in large part on their own efforts to help themselves. Aspirin in large doses will be helpful. but oral or injected morphine or its equivalent should be reserved for use only after the patient is in a situation where there is some person to take care of him. Hypodermic injections of morphine must not be given to patients in or near shock because it will not be absorbed. If such ineffective doses are repeated and later the patient comes out of shock he may have received a fatal dose and die. Such patients should be given morphine intravenously.

This excerpt is from an article on treatment of atomic burns but the admonition could well apply to any major disaster. Ampoules of morphine ready for I.V. use should be on the list of supplies for disaster committees and teams.

Philosophy In Medicine

IN THESE days of highly specialized (and high-powered) research, plus high-pressure salesmanship, backed up by kymographic tracings and other mechanized weapons of modern science, it is refreshing, as a rule, but sometimes startling, to hear an occasional blast along Hippocratic lines from some observer who can still see the forest as well as the trees. The following appears as an editorial in the January 1951 number of *Minnesota Medicine*:

CORTISONE and ACTH are powerful drugs—atomic-like in action! I recall the lectures at the Mayo Clinic of that philosopher-king, the late Dr. Henry Plummer, on myxedema patients. He would compare the myxedema patient to an automobile deeply mired in the mud. To free the car, he explained, one would have to slowly ease it out of the mud. A quick pull, or the application of an explosive force would liberate the car to be sure, but it would also tear it to pieces with the force. So Doctor Plummer, knowing the myxedema patient was mired in deep physiological stasis due to lack of thyroid substance, would, by the same process of reasoning as in the liberation of a mired car, ease the patient back to the highway of well-being by prescribing small doses of thyroid to start with and, gradually, over weeks and months, increasing the dose until normalcy was achieved.

I have followed the use of Cortisone and ACTH, through excellent reports. Just recently have these drugs become universally available to the medical profession. I have not yet used them. I fear and respect their latent powers. Were I to use them, I would surely follow Doctor Plummer's rule in their administration—small doses over months of time in order to give the mired body an opportunity to ease out of the deplorable condition it is in. One must remember that the majority of conditions for which these drugs are used, have developed over a period of years. To expect to bring about a complete restoration in a few weeks' time is too drastic. Is it any wonder that one encounters serious complications such as mental changes, diabetes, perforated gastric ulcers, skin manifestations of hirsutism, hyperpigmentation, striae atrophica, to say nothing of possible injury to tissues—injuries not observable right away, injuries that may, in time, show up and possibly cause more serious trouble than that with which the patient is already suffering. It seems to me, too little time has passed by to allow these powerful drugs to be used universally. More time and study, especially on more remote effects, should be given. Doctor Plummer's technique in the administration of these drugs should be given a thorough consideration.

These drugs are really ATOMIC in power!

J. J. Heimark, M. D.

In his discourse on Ancient Medicine, Hippocrates said " . . . we ought not to reject the ancient Art, as if it were not, and had not been properly founded, because it did not attain accuracy in all things, but rather, since it is capable of reaching to the greatest exactitude by reasoning, to receive it and admire its discoveries, made from a state of great ignorance, and as having been well and properly made, and not from chance." Truly, we still need the Art as well as the Science.

The Retort Laconic

From the breezy West, the *Rocky Mountain Medical Journal*, March 1951, comes a "short, short story" that packs a wallop (as well as prompting a smile). Reading time 1 minute:

Many current publications, both medical and lay, have been full of comment regarding an article entitled "Letter to a Family Doctor" by Mr. Bernard De Voto, which appeared in the January, 1951, issue of Harper's Magazine and in the February issue of Medical Economics. Comment in the Journal A.M.A. and others has shown that physicians, as a group, felt especially insulted by the article. Many have answered at length. The briefest we have seen, and one of the best, was from a Denver doctor. Here it is:

Mr. Bernard De Whoosit,
49 East 33rd Street,
New York 16, N. Y.

Dear Sir:

Your circular "Letter to a Family Doctor" was read with interest. May I have copies of the circular letters to your grocer, butcher, tailor, shoemaker, haberdasher, liquor dealer, tobacconist, tax collector and baby sitter?

Thanking you,

Very truly yours,
WILLIAM H. HALLEY, M.D.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

A DOCTOR SHORTAGE AGAIN

The military force of 3½ million, now scheduled for mid-1951, will require the services of 13,000 doctors, 6,500 dentists and 16,000 nurses. That's the estimate of the defense department, which has authority to call on selective service for doctors and dentists—but not nurses—if requirements are not filled through volunteering.

The medical men needed before July 1 represent something over 8 percent of all doctors and dentists now in private practice. The very much larger numbers that would be needed under full mobilization are compelling consideration of how best to meet military requirements without reducing health care of the civilian population to the danger point.

These expanding military calls come at a time when resources in health personnel are already inadequate in some sections. Sixteen states have more than twice as many people per doctor as New York state, where the doctor-population ratio is most favorable. Twenty-one states have twice as many people per dentist. The shortage of nurses is widespread. Generally speaking, urban areas are better supplied than rural districts.

Whether or not the present supply of health personnel is adequate for civilian needs in peacetime, there is no question that even the largest cities would suffer acute shortages in case of enemy attack. Telling of health planning by the national security resources board, Dr. H. A. Rusk said:

"We realized we could not be profligate again, as we were in the last war, for if we got into a catastrophe it would be a different kind of a blow, and we would not have enough facilities to do the job."

President Truman took note of the situation in his message to congress last month when he called for legislation "to increase the supply of doctors, nurses and other trained personnel critically needed for the defense effort."

Before we started the rearming program, the U. S. public health service estimated that at current rates of graduation from medical schools, the country would be short 15,000 doctors, 5,000 dentists and perhaps 50,000 nurses by the end of 1960. Now it is estimated that the doctor shortage will exceed the figure estimated for 1960 in 1954 if the armed services are expanded at an annual rate of 500,000 after mid-1951.

When we talk about enlarging the nation's resources of medical personnel, we run into the fact that the professional schools are now operating at capacity and the further fact that most of them are operating in the red. Last year's deficits of 79 approved medical colleges were estimated at $10 million, about a fifth of their combined budgets. And three-fourths of the qualified applicants for enrollment were turned away.

Bills now awaiting action by congress would authorize federal grants to professional schools to help meet the widening gap between the cost of instruction and the income available from tuition, endowment and other sources. Also proposed is rapid expansion of training facilities for practical nurses.

The army has estimated its present needs on the basis of four doctors, two dentists and five nurses per 1,000 servicemen. These ratios, particularly for doctors, have been criticized in congress as needlessly extravagant and far out of line with the peacetime ratio of one doctor to about 1,000 civilians.

In support of the 4:1,000 ratio, the army points out that the military medical officer, in addition to caring for battle casualties, must control living conditions of the men in his charge and exercise other preventive techniques which are usually outside the civilian doctor's responsibilities.

To safeguard civilians, the national security resources board has set up a health advisory committee which, with affiliated state civilian committees, will classify health personnel as either essential to their local communitities or available for military service. This committee will advise selective service if the doctor-dentist draft law is invoked. According to the defense department, drafting cannot be long delayed unless there is a rapid step-up in the rate of volunteering.

Rearming is going to impose more problems for the home front than just a reduction in the manpower and materials available for civilian production. One of those problems apparently will be a restriction on our medical care resources.

—The Gary Post-Tribune

MALPRACTICE INSURANCE FOR PHYSICIANS IN THE ARMED SERVICES

ALBERT STUMP*

INDIANAPOLIS

IT IS AS important to the physician in the Armed Services, or in any other service of the Government for that matter, to carry malpractice insurance as it is for him to carry it when not in Government service. The same degree of care, diligence and professional ability required of a physician in caring for patients in civil life is required by law of a medical officer in the Armed Services.

Medical officers are held to the same standards in treating the families and dependents of men and women in Government service as they are in the treatment of paying patients in civil practice. This is true whether the service is paid for or not. It is likewise true in regard to medical treatment of charity patients, welfare recipients, or persons in any other group or classification.

No matter what the circumstances are under which a physician undertakes to render professional services, the standards to which he must conform are always the same; and his liabilities for failure to conform to such standards are the same.

If a claim were brought against a medical officer on a charge of malpractice in the performance of his official duties, according to its practice in the past the Government would provide defense, but it would not pay any judgment rendered against the physician nor reimburse him for any judgment he might pay. In the past the Attorney General, on request of a Government department or agency, has provided defense in civil suits for malpractice arising out of the activities of physicians from such departments or agencies in the discharge of their official duties.

Where a physician quits his civilian practice to enter the Armed Forces and leaves the practice to some other physician to preserve it for him until his return to civil life, there is the possibility that the physician to whom it is left, as well as the physician who left it to enter the Armed Services, could both be liable for malpractice on the part of the physician left in the office. Whether liability exists would depend upon the type of contract or agreement made between the physician entering the Armed Services and the one holding his place. If the latter is an employee of the former, then the doctrine of agency would apply, and both could be liable. On the other hand, if the arrangement is on the basis that the doctor holding the office would be practicing entirely upon his own, and collecting and keeping whatever fees he earned as his own money, and then paying something to the departing physician in the way of rent or for the privilege of practicing from that office, then the physician in the Armed Services would not be liable for the holding physician's malpractice.

Since the answers to these questions are to be found in the evidence and the jury is the judge of the evidence, it is still the part of wisdom to carry malpractice insurance of broad coverage that will protect the physician against any claims for malpractice that may be made against him.

The policy issued by St. Paul Mercury Indemnity Insurance Company, the company which was recommended by the Indiana State Medical Association some years ago for malpractice insurance, affords as broad an insurance coverage as we know of.

* Attorney for the Indiana State Medical Association.

LIFTING MOTION DOUBLES EFFECTIVENESS OF ARTIFICIAL BREATHING

A simple lifting or rolling motion, added to the usual prone-pressure method, makes artificial respiration twice as effective.

The lifting action, described by Dr. A. C. Ivy, head of clinical science at the University of Illinois, consists merely of lifting the victim's hips four inches between applications of pressure to the lower chest region. The lift need be applied only 12 times a minute to double the effectiveness of the commonly-used Schafer method of forced breathing, he said.

One drawback to the hip-lifting action is that the person giving it rapidly tires, Dr. Ivy said. As an alternative, he suggested a hip-rolling action that has also been found to improve the prone-pressure method.

News Notes

MENTAL HEALTH COUNCIL NAMES HOSPITAL HEAD

The Indiana Council of Mental Health has announced the appointment of Dr. Juul C. Nielsen, superintendent of the Hastings, Nebraska State Mental Hospital, to become head of the new Larue D. Carter Memorial Hospital which will be completed this fall. The $5,000,000 institution providing 250 beds, is under construction adjacent to the Indiana University Medical Center, Indianapolis, and will be an active treatment and research center for mental illnesses, and the training of physicians, nurses and other professional persons in psychiatry.

Under a law enacted by the 1951 General Assembly, Doctor Nielsen will serve as medical director of the council, and Arthur G. Loftin, now acting director, will become its administrative director. Under the same act, which empowered Governor Henry F. Schricker to name two lay members to the council, Ray E. Smith, executive secretary of the Indiana State Medical Association, and Edward P. Gallagher, executive vice-president of American States Insurance Company, both of Indianapolis, were appointed.

Doctor Nielsen was born in Denmark, and became a naturalized citizen prior to serving in World War I. He was chief of the mental hygiene consulting service at Fort Riley, Kansas, in World War II. A graduate of the University of Nebraska College of Medicine, he was certified as a diplomate by the American Board of Psychiatry and Neurology in 1938 and is a member of national psychiatric groups.

DEDICATION DATE SET

August 19, 1951, has been named as dedication day for the new eight million dollar Veterans Hospital at Indianapolis, west of the Indiana University Medical Center. Dr. Earl H. Hare, who has been with the Cold Spring Road VA Hospital at Indianapolis since it was opened and manager since July 1946, will become manager of the new hospital. It is planned later to devote the Cold Spring Road hospital to tuberculosis patients.

Dr. Clifton H. Smith has been appointed to succeed Doctor Hare as manager of the Cold Spring Road VA Hospital, but no effective date has been announced. He has been connected with Veterans' affairs since 1924, and at present is manager of the VA Hospital at Atlanta, Georgia.

AMERICAN ACADEMY OF GENERAL PRACTICE

The National meeting of the Academy of General Practice was held in San Francisco March 18 to 22. There was a total registration of 4200. Thirty-one members of the Indiana Academy were present. Delegates from Indiana were Dr. O. T. Scamahorn and Dr. Norman Booher. Dr. Booher was selected as vice-speaker of the Congress of Delegates for the ensuing year. Dr. J. P. Saunders of Louisiana assumed the office of President, and Dr. R. B. Robins of Arkansas was elected as President-elect.

OHIO STATE UNIVERSITY

The physician-president of the University of Washington, Dr. Raymond B. Allen, will deliver the dedication address for the new Ohio State University Medical Center, Tuesday, May 15. The program will be held out-of-doors at 11 a.m. in the Medical Center quadrangle.

These ceremonies, and the scientific sessions to precede and follow, will bring to Columbus a distinguished group of physicians, dentists and nurses. They will join with faculty, students and alumni of the university, as well as Gov. Frank J. Lausche and state officials in dedicating the new $15,500,000 center to the people of the state.

COMMITTEE TO STUDY MEDICAL SCHOOL EXPANSION

Dr. Merrill S. Davis, of Marion, has been named by Governor Henry F. Schricker to head a five-member committee created by the 1951 General Assembly to make a study of possible expansion of Indiana University School of Medicine with the view of turning out more physicians to meet the increasing need.

Lay members of the committee are: Virgil M. Simmons, publisher of the *Fort Wayne Journal-Gazette;* Dr. O. P. Kretzmann, president of Valparaiso University; Carl F. Eveleigh, executive vice-president of Eli Lilly & Company; and Senator Leo J. Stemle, Jasper attorney, Democratic minority leader in the Senate.

The seventeenth annual meeting of the American College of Chest Physicians will be held at the Ambassador Hotel, Atlantic City, New Jersey, June 7 through 10, 1951. An interesting scientific program has been arranged for presentation at the meeting.

Dr. James H. Stygall, Indianapolis, serves as Chairman of the Board of Regents of the College. Dr. Jerome V. Pace, New Albany, is Governor of the College for Indiana.

OFFICERS CHOSEN FOR INDIANA ACADEMY OF GENERAL PRACTICE

Clarence H. Rommel, M.D., of West Lafayette became president of the Indiana Academy of General Practice at the annual meeting held at Indianapolis April 10-11, 1951, succeeding Maurice V. Kahler, M.D., of Indianapolis. Other officers elected were:

President-elect—Russell J. Spivey, M.D., Indianapolis.

Vice-president—Philip E. Yunker, M.D., Evansville.

Directors, term expires 1954—Clarence C. Herzer, M.D., Evansville; Bernard E. Edwards, M.D., South Bend; Francis P. Jones, M.D., Indianapolis.

Delegate to A.A.G.P.—O. T. Scamahorn, M.D., Pittsboro.

Alternate to A.A.G.P.—Louis E. How, South Bend.

Held over in office were:

Secretary-Treasurer—Norman R. Booher, M.D., Indianapolis.

Directors, term expires 1952—Harry L. Foreman, M.D., Indianapolis; L. E. Foltz, M.D., Brownsburg; Russell J. Spivey, M.D., Indianapolis.

Directors, term expires 1953—Walter Portteus, M.D., Franklin; William Tindall, M.D., Shelbyville; Michael Shellhouse, M.D., Gary.

Delegate to A.A.G.P.—Norman R. Booher, Indianapolis.

Alternate to A.A.G.P.—George W. Herrold, Lafayette.

Registration at the recent Indiana Academy was reported as 405, and committees in charge regarded it as a very successful session. The next meeting will be held at Indianapolis in April, 1952.

PHYSICIANS ART SHOW

The American Physicians Art Association will have an art exhibit, as usual, during the A.M.A. convention at Atlantic City, N. J., June 11 to 15, 1951, inclusive. Any physician in the United States, Canada and Hawaii desiring to participate in this show should communicate with the secretary for particulars.

J. Henry Helser & Co., Inc., Investment Managers with offices on the Pacific Coast, are the new sponsors of the American Physicians Art Association and will award 200 trophies besides a special Helser Trophy—a large decorative cup depicting Yankee Ingenuity. This cup is to be awarded for art work done in any medium. Also the large Popularity Trophy will be awarded to the owner of the art piece receiving the most popular votes during the A.M.A. convention. Over 4,000 members of the American Physicians Art Association will receive shortly, entry blanks, shipping labels and rules about this fourteenth art exhibition.

The annual Art Banquet will be held Tuesday evening, June 12 at the Marlborough-Blenheim Hotel, Atlantic City, N. J. For further information address F. H. Redewill, M.D., Secretary, American Physicians Art Association, 760 Market Street, San Francisco 2, California.

DOCTOR MENNINGER GUEST SPEAKER

William C. Menninger, M.D., of Topeka, Kansas, one of the outstanding psychiatric leaders in America, and consultant to the Army's surgeon general on psychiatric matters, spoke at the Indiana University Medical Center at Indianapolis April 12. He discussed the problems of civilian physicians in military service and the relation of psychiatry to military medicine.

At a luncheon meeting of the Indiana Mental Hygiene Society held at noon April 14 in the Claypool hotel, Indianapolis, Doctor Menninger gave another address, highlighting an all day meeting of the society for its second annual conference. C. Oliver Holmes, of Indianapolis, society president, introduced the speaker.

GOVERNING BOARD MEMBERS NAMED TO AID NORWAYS

A governing board has been formed by Norways Foundation, operating organization of the Norways Psychiatric Sanatorium, 1800 E. 10th Street, Indianapolis, to advise the institutions' trustees in attaining their goal of leadership in research, training and treatment of mental illness, according to Edward F. Gallahue, president of the board of trustees. The foundation plans to enlarge the Norways graduate training program for physicians as well as for psychiatric nurses, psychologists, social workers and other psychiatric workers. A joint meeting of the trustees and governors was held April 14, at which Dr. William C. Menninger, M.D., of Topeka, Kansas, nationally known psychiatrist, and member of the new governing board, was present.

Other members of the new governing board are: Dr. Edward G. Billings, Denver, Colo.; Dr. Richard L. Frank, New York City; Ralph F. Gates of Cambridge City; Telford Orbison, New Albany; Sarkes Tarzian, of Bloomington; and Alan C. Appel, Volney M. Brown, Dr. James W. Denny, W. J. Holliday, Jr., Richard T. James, Mrs. J. K. Lilly, Rev. Jean S. Milner, Charles S. Rauh, and Thomas E. Reilly, all of Indianapolis.

INSTRUCTOR IN RADIOLOGY

Dr. James G. Lorman has been appointed to the staff of Indiana University School of Medicine as an instructor in radiology, according to announcement made by Dean John D. Van Nuys. Doctor Lorman graduated from Indiana University School of Medicine in 1944 and served an internship at Grace Hospital, Detroit, before entering the Army Medical Corps. After duty in hospitals in Korea and Japan he returned to Indiana University Medical Center, completing four years of residencies in pathology and radiology.

THIRD ANNUAL TUMOR SEMINAR

The Billings Hospital of the Veterans Administration, in conjunction with the Indiana Cancer Society, the Indiana State Board of Health, the Indiana University School of Medicine, and the Indiana Association of Pathologists, is conducting a third annual tumor seminar Sunday, May 27. The subject is "Diseases of Lymphoid Tissue." The moderator is Dr. R. Philip Custer of the Presbyterian Hospital, Philadelphia, Pennsylvania. A limited number of slide sets are available. These may be obtained directly from Dr. Lall G. Montgomery, Ball Memorial Hospital, Muncie, at $10.00 for each set. All are cordially invited to attend, whether or not you register for one of the slide sets. Luncheon reservations should be made with Dr. Marvin N. Solomon, Billings VA Hospital, Fort Benjamin Harrison, Indianapolis 16.

DOCTOR STAYTON HONORED

An award of merit has been presented to Dr. Chester A. Stayton of Indianapolis by the American Cancer Society for outstanding voluntary service in cancer control. These awards may be presented to lay or professional people and are voted by the Board of Directors of the national society. There were twenty-three such awards made this year. Doctor Stayton has given long and valuable service to the cancer control movement both in the Indiana Cancer Society and the Indiana State Medical Association. He served for several years as chairman of the association's Cancer Committee and is currently chairman of the Executive Committee of the Indiana Cancer Society. The only other Hoosier holding this award is Dr. Thurman B. Rice of Indianapolis.

The Dearborn County unit of the Indiana Cancer Society was also singled out recently by the American Cancer Society for its splendid program of cancer education and service. Mrs. E. L. Schneider of Lawrenceburg is chairman of the unit.

Dr. Daniel M. Hare has been notified that he is certified as a diplomate of the American Board of Urology. Graduated from Indiana University School of Medicine in 1940, he interned at Eloise, Mich., served a two year residency at Indiana University Medical Center and was in military service from 1943 to 1946. Later he spent three years as resident in urology at Parkland Hospital, Dallas, Texas, and now is associated with Dr. Robert R. Acre, 617 Hulman Building, Evansville.

Dr. Russell S. Wharton has assumed duties on the staff of Marion VA Hospital, coming from the VA hospital at Northampton, Mass. He replaces Dr. C. L. Williams, who was transferred from Marion to the VA hospital at Lexington, Ky.

SEMINAR IN ANESTHESIOLOGY

Indiana University School of Medicine

May 16, 1951

Sponsored by Indiana University School of Medicine
and
Indiana State Society of Anesthesiologists

8:00- 8:30—Registration, Office, Department of Anesthesiology, Laboratory Science Building, Room #113

8:30-10:50—Clinics, Operating Rooms in Clinical Building and Riley Hospital

10:50-11:00—Remarks of Welcome—
John VanNuys, M.D., Dean
Indiana University School of Medicine

11:00-11:30—"Etiology and Treatment of Post-Spinal Headaches"
John E. Krueger, M. D.
Department of Anesthesiology
Indiana University School of Medicine

11:30-12:00—"Clinical Evaluation of Surital Sodium for Intravenous Anesthesia in 1000 Patients"
Paul A. Littlefield, M.D.
Department of Anesthesiology
Indiana University School of Medicine

12:15- 1:15—Dinner. Round Table Discussion, Dining Room, Riley Hospital

1:30- 2:00—"Diagnostic and Therapeutic Nerve Blocks in the Practice of Medicine"
E. A. Rovenstine, M.D.
Professor of Anesthesiology
New York University Medical College
New York, New York

2:15- 2:45—"The Use of Nitrous Oxide in the Practice of Anesthesiology"
Frederick W. Clement, M.D.
Toledo, Ohio

2:45- 3:00—Recess

3:00- 3:30—"The Comparison of Various Curares in the Field of Anesthesiology"
Max Sadove, M.D.
Professor of Anesthesiology
University of Illinois School of Medicine
Chicago, Illinois

3:45- 4:15—"Spinal Anesthesia"
Lloyd E. Larrick, M.D.
Cincinnati, Ohio

(The hours indicated on this program will be Central Daylight Saving Time)

Not only enough bulk ...but plenty of water



...with METAMUCIL®

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

To assure the patient of the necessary quantity of liquid and natural mucilloid expedient to the promotion of peristaltic movement, Metamucil is to be taken with a full glass of cool liquid and may be followed by another glass of liquid if indicated.

Metamucil, mixed with water, produces:

. . . . a bland mass which is intimately miscible with the intestinal contents and is extended evenly throughout the digestive tract

. . . . gentle stimulation of the bowel wall, initiating normal reflex peristalsis

. . . . medium stools—not hard, not soft

. . . . no irritation, straining, impaction and

. . . . no interference with digestion or absorption of oil-soluble vitamins.

METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

REHABILITATION OF OLDER HANDICAPPED PERSONS

The University of Michigan announces its Fourth Annual Conference on Aging to be held in Ann Arbor, July 11-13. Rehabilitation of the older handicapped person will be the topic of this year's conference. American and foreign authorities will be available to discuss the questions raised by the working conference. Attention will be directed to medical, psycho-social, economic and vocational aspects of retaining the over-40 workers in the labor force and the role of these workers with reference to mobilization.

Room reservations should be made by writing directly to the Michigan Union, Ann Arbor. For further information regarding the conference write to Dr. Wilma Donahue, Institute for Human Adjustment, Room 1510, Rackham Building, Ann Arbor, Michigan.

1903 CLASS REUNION

The class of 1903 of Indiana University School of Medicine will have a dinner meeting at 11:00 a.m., May 20 at Turkey Run State Park Inn. It is one of two classes of Indiana University School of Medicine which hold annual class reunions. Three past presidents of the Indiana State Medical Association are members of this class: Drs. Charles N. Combs, of Terre Haute, Dr. F. S. Crockett, of Lafayette, and Dr. J. E. Ferrell, of Fortville.

Dr. Leo N. Kirch, associated with Dr. Alvin Newman since 1948 at 912 Hulman Building, Evansville, has been certified as a diplomate of the American Board of Urology. After graduating from Indiana University School of Medicine in 1939, he interned at Indianapolis General Hospital and served a year's residency there before military service from 1941 to 1946. He returned to the hospital for two more years residency, specializing in urology, before beginning practice in Evansville.

Dr. Edward S. Shelley has moved to new quarters for general practice of medicine at 728 West Colfax Avenue, South Bend. He was graduated from Indiana University School of Medicine in 1944, and has been practicing in South Bend since release from the United States Navy in 1946.

MEDICAL SOCIETIES AID HOSPITAL

Members of Lake County Medical Society have been making calls at the new Norman Beatty Mental hospital near Westville for medical and surgical fees "that barely cover the cost of gas and oil," in response to pleas of Dr. H. G. McMahan, superintendent of the hospital, who had explained the awkward financial situation there, the small staff, and few patients so far admitted. Doctor McMahan is making similar appeals to medical societies in St. Joseph, LaPorte and Porter counties.

Dr. C. M. Harless has moved from Miller to Chesterton, and has offices for full time practice there in the west wing of the building formerly occupied by Dr. Joseph Dale. Formerly he had practiced at Anderson, Markel, and Gary, but later divided his time between Gary and Chesterton.

Dr. Jacob T. Oliphant, of Farmersburg, has been reelected unanimously as chairman of the Indiana State Board of Health. He has held offices in the organization since 1937.

An Alcoholics Anonymous group has been formed at Longcliff, with **Dr. Leonard Lund** of the Logansport State Hospital staff supervising the meetings. The Logansport AA chapter also assists.

Ideas of Evansville doctors on the layout for the proposed new St. Mary's Hospital, will be referred to the architect for incorporation in plans for the building, to be erected on the east side between Lincoln and Washington avenues, Evansville.

Dr. Richard G. Burman, Jeffersonville obstetrician since 1938, has accepted a medical fellowship at Tulane University, and will do clinical work at New Orleans Charity Hospital in addition to his teaching fellowship duties. **Dr. William R. Witt**, who recently became associated with Doctor Burman, will continue in charge of their office in Jeffersonville.

Dr. Roger C. Smith, of New Haven, has accepted a three-year fellowship in Internal Medicine at Mayo Foundation, Rochester, Minn., and plans to resume work at New Haven later. Doctor Smith graduated from Indiana University School of Medicine in 1944, interned at Grace Hospital, Detroit, and held residency at Wyandotte Hospital, Wyandotte, Mich., before becoming a Captain in the Medical Corps and serving approximately two years in west coast army hospitals. He has been associated with his father, Dr. G. A. Smith, and brother, Dr. Richard B. Smith.

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Indiana University News Notes

Admission of 150 students from 70 Hoosier communities to the Indiana University School of Medicine was announced by Dean John B. VanNuys today following the annual selections by the School's admissions committee.

More than half of the state's counties are represented in the class, which is the fourth of the entering groups expanded to 150 from the School's normal capacity of 120 to meet the state's needs for more doctors. With the enrollment of the new class next fall more than 550 students will be in medical training at the University.

The students chosen for admission were selected from 394 applicants by a faculty committee of sixteen members headed by Dr. James O. Ritchey, chairman of the School's department of medicine.

Though students selected for medical school are not automatically deferred in the draft, Dean VanNuys said it is presumed that they will be permitted to go on with their training because of the military as well as civilian demand for doctors.

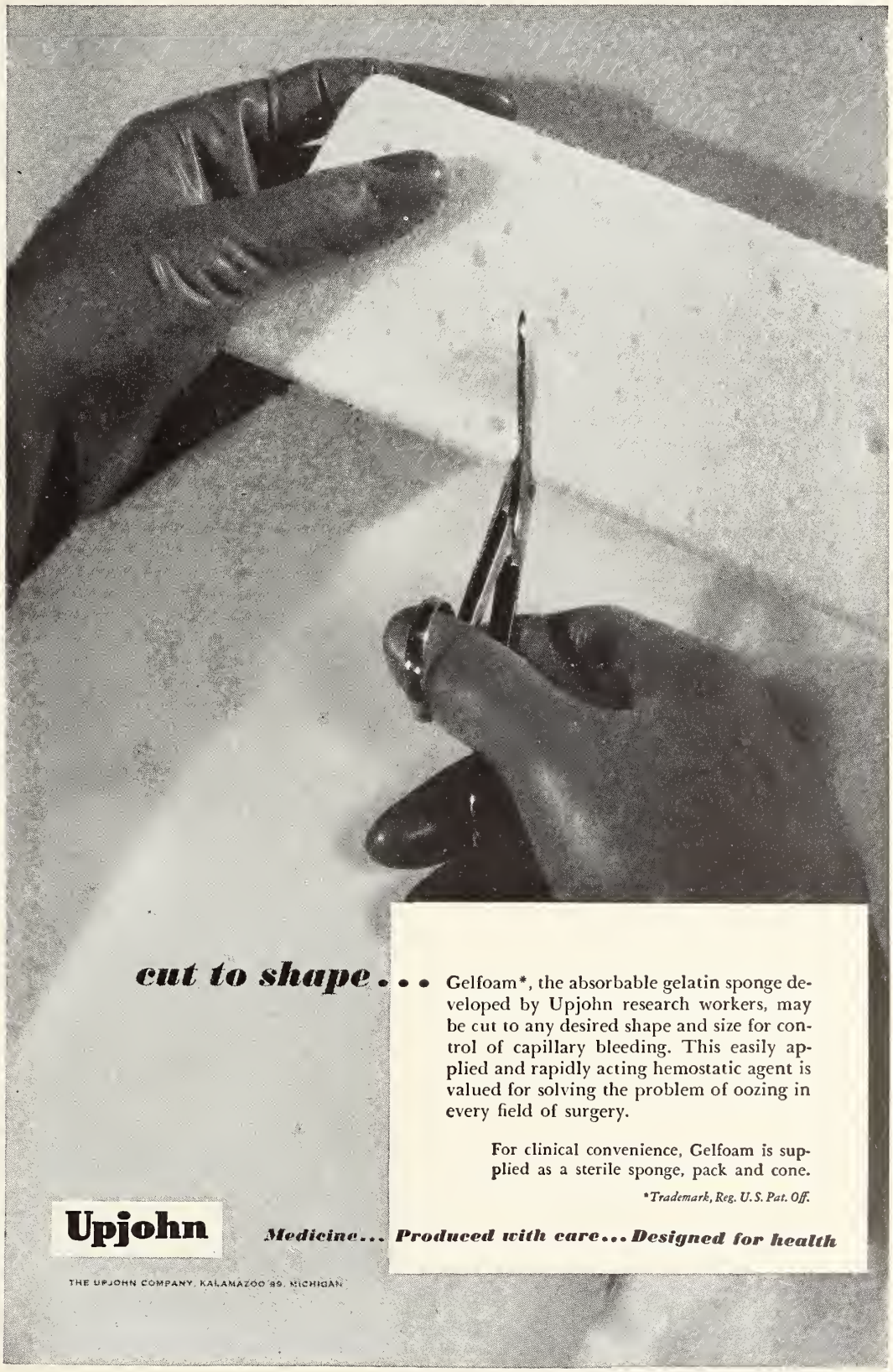
The list of students admitted is as follows:

Vincent B. Alig, James A. Benz, Robert Allen Brewer, Robert E. Brubeck, Robert F. Casse, Marvin C. Christie, William A. Duncan, Gabra S. Gachaw, Hardin B. Grigsby, Fred A. Hendricks, Jack W. Hickman, Patricia Mae Hilficker, Jim Charles Hirschman, James M. Jay, Gordon C. Jones, Ross W. Lambert, John Wood Lee, Francis Edward McAree, Robert J. Madden, Toner M. Overly, Robert M. Palmer, Richard C. Powell, Reed P. Rice, Edward B. Rosabaugh, Robert E. Snodgrass, Robert E. Suess and Isadore Talesnick, Indianapolis; Roland C. Ahlbrand and Robert L. Smith, Kokomo; James A. Arata and Frances A. Kohler, Mishawaka; John E. Arford, Washington; Robert M. Armer, Jr., George H. Franck, Sheldon W. Grinnell, Loren F. Taylor, Terre Haute; David S. Ayres, Redkey;

Reginald R. Barton, James L. Kasiser, David E. Karges, Raymond W. Nicholson, Jr., Marylee Schlamp and James R. Stanton, Evansville; Paul V. Bello, Riverdale, N. Y.; Ralph B. Billerbeck, Beverly Shores; John W. Bitzer, Lagro; Patricia June Birum, Union City; Max L. Boone, S. Dale Loomis, Jr., and George A. Teaboldt, Jr., Peru; Louis F. Bradley, Montgomery; David W. Buck, Decatur, Ill.; Charles E. Bush, Jr., and James A. Harshman, Lafayette; Bob R. Cagle, Brazil; Henry L. Charles, Economy; James A. Chase and Robert J. Nickels, LaPorte; Robert C. Colvin, Newburgh; Walter J. Daly, Lawrence J. Lawson, and Robert T. Sargent, Muncie; Louis P. Doyle, West Lafayette; William E. Dye, Oakland City; Donald E. Edgar, Robert E. Edgar and William H. Townsley, Princeton; Matthew J. Fadell and Alfonso D. Holliday, Jr., Gary; William G. Fateley and Carl E. Shrader, II, Franklin; Robert E. Fenstermacher, Upland; Charles H. Frie, Stephen H. Glassley, Robert L. Koenig, Frederick W. Kurth and Herbert P. Trier, Fort Wayne; Sidney E. Friedman, Newark, N. J.; Robert M. George, David Giordano, Elliot Liff and Charles R. Moore, South Bend; William F. Gessler, Jr., Marguerite Thompson Hays, Donald A. Kellogg, A. J. May, James B. Ross, Bill B. Smiley and Edward F. Steinmetz, Bloomington;

Roy L. Gibson, Rising Sun; Alfred D. Hauersperger, Hanover; Jesse D. Hayes, Jr., Frank J. Kmak and Victor E. Schlossberg, Jr., East Chicago; Ernest A. Hershey, Jr., Churubusco; Horace D. Hinshaw, Connersville; Galen C. Huffman, Poneto; Gene E. Johnson, Sheridan, Wyo.; David G. Jones, Charles D. Kline, Jack C. Moore and William T. Wilder, Anderson; Richard L. Jontz, Silver Lake; Robert W. Karch and Donald B. Rudy, Bluffton; James R. Kerr, Attica; Ee Chuan Khoo, Singapore, Malaya; Richard M. Kingery and Morton D. Willcutts, Jr., Greentown; Robert M. Kintner, North Manchester; Edwin F. Koch, Jr., and Robert St. John, Jr., Shelbyville; Robert N. McAlpine, James R. Nicholas and Richard J. Noveroske, Michigan City; Morris E. McClure, Decatur; Thomas R. Marshall, Charlestown; Donald G. Miller, Goshen; Joe Bill Mishler, Akron; George L. Mitchell, Danville; John M. Moore and Ralph M. Pratt, Jr., Madison;

George G. Morrison, Jr., Portland; Harold G. Nichols, Knox; Richard T. Nolin, Fowler; Marcene Pearcy, Martinsville; Allen D. Pierson, Crawfordsville; John Reed and John H. Tedford, Frankfort; Robert L. Rubright and Jack Schwartz, Hammond; Maxine Salesman, Jeffersonville; Paul R. Santrock, Nitro, W. Va.; Waldo S. Scales and Charles G. Spradley, Boonville; Arthur Schoonveld, DeMotte; Fred Smith, Jr., Bristow; Robert G. Stanley, Waterloo; Bill Stinson, Alexandria; Guenevere Strycker, Macy; Jerry L. Stucky, Berne; Donald G. Tatlock, Salem; George M. Underwood, Noblesville; Paul C. Vietzke, Valparaiso; Paul M. Waitt, Sheridan; Thomas W. Wallace, Marion; Marlin E. Weaver, Wabash; William R. Wells, Rolling Prairie; Everett D. Wilson, Perrsyville, and Mary Barbara Yeager, Rockport.


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A.M.A. WASHINGTON OFFICE NEWS

Medical College Association Demands 'Remedial Steps' in VA. The Association of American Medical Colleges, 50 of whose member colleges are affiliated with VA hospitals, has called for some "remedial steps" *to insure that VA's medical program continues under medical direction.* The association's views were presented by Dr. Joseph C. Hinsey, dean of Cornell Medical School, to a special Senate committee investigating the ouster of Dr. Paul Magnuson as VA medical director.

Dr. Hinsey said schools participating in VA medical plans are "gravely concerned for the future welfare of the program." He told the Senators that Dr. Magnuson's removal was a "forced resignation." He said that difficulties over the program, increasing over the last two years, "*threaten the continued existence of the present excellent medical program,*" and that signs pointing toward a breakdown are "clearly evident." However, Dr. Hinsey made it plain that the association is giving its "wholehearted support" to *Vice Admiral Joel T. Boone,* Dr. Magnuson's successor.

At the time he was removed, Dr. Magnuson blamed long-standing policy disagreements between him and Administrator Carl R. Gray, Jr. Dr. Magnuson said Mr. Gray was making changes that threatened bureaucratic control of VA's medical program. Mr. Gray accused Dr. Magnuson of attempting to set up a medical department "virtually independent of the administrator." He said the changes would not affect medical care.

Subcommittee Chairman Hubert Humphrey (D.-Minn.) elaborated on the situation, after hearing Dr. Magnuson and Mr. Gray at executive sessions. "The issue involved here," said the Senator, "is whether or not the director of medical services would have general administrative supervision not only over professional medical services, but over such auxiliary or supplemental aspects of medical care as hospital management, hospital construction and special services related to treatment." All hearings were private, with Senator Humphrey releasing some information on testimony after each session.

Blood Program Equipment and Supplies To Be Standardized. Week-long meetings at Red Cross headquarters in Washington resulted in agreement for complete standardization of supplies used in the blood program, from collection to transfusions in the field. No one agency will be final authority on details, but agreement will be worked out by National Research Council, National Institutes of Health, Defense Department and Red Cross. For the first two days, Dr. Ross T. McIntire's blood program staff met with representatives from commercial laboratories, Public Health Service, Civil Defense Administration and the military establishments. Later in the week Red Cross area representatives and nurses met with representatives from commercial and other laboratories involved in the blood program. Dr. McIntire said the hope is that eventually blood and plasma supplies and equipment will be standardized internationally as well as nationally.

Biological Warfare Pamphlet Released. Civil Defense Administration today releases "What You Should Know About Biological Warfare," a pamphlet designed to acquaint the public with all phases of BW; its threats, its limitations, known defenses and what the public should do in face of the danger. Throughout the booklet, the dominant role of the medical profession, public health service particularly, in protection against BW is emphasized.

The pamphlet is written simply and forcefully, printed in large type with plenty of headings and subheadings. It scrupulously avoids any scientific jargon that might frighten off the general public; when scientific terms have to be used, they are explained in words that almost anyone would have to understand.

Dean Clark Committee Delays Filing of Health Report. The Senate subcommittee which has been surveying voluntary health plans and state and local health services has asked more time to complete its report. In a statement filed with the Senate, the subcommittee outlined its progress to date, but said it wanted to revise its preliminary report on the basis of recommendations from groups which cooperated in gathering the material. The survey was directed by Dr. Dean Clark. It is understood there have been objections to some of the conclusions in the first draft. A committee source said it would be six weeks or so before a final report is released. Deadline is May 25.

First of a Series
May, 1951

KNOW YOUR PLAN

Physicians Organized Blue Shield Plan

In 1946 the House of Delegates of the Indiana State Medical Association voted approval for the establishment of "The Doctor's Plan" now known as Blue Shield Plan. This was to be an Insurance Company, organized for the purpose of writing an indemnity type Insurance Policy that would indemnify an individual and his family against the cost of surgical, obstetrical and medical care.

Following approval for the formation of the Plan, Indiana physicians personally loaned almost one hundred thousand dollars to get the Plan in operation. These physicians have all had their money returned and for several years the Plan has operated on its own business income.

Indiana physicians, like physicians in many other sections of the nation, realized the need for a sound method of providing a means whereby families could protect themselves against the cost of sickness. It was far from the desire of Indiana physicians to get into the insurance business. Attempts were made to interest the commercial insurance companies in writing a policy which would provide the protection the doctors felt necessary, and to prepare a policy which would protect entire families at a rate they could afford.

This proposal was turned down by every insurance company—so the physicians organized their own Plan and went into the insurance business in September 1946, not from a profit making motive, but as a humanitarian move to make it easier for the people to receive the medical care they desired, and to make it possible for them to pay their bill without undue financial hardship.

The Doctor's Plan changed its name to Blue Shield in 1948 and today operates as "The Blue Shield Plan." It is incorporated as Mutual Medical Insurance, Inc., a non-profit corporation, sponsored and operated by a board of directors, nominated by the Council of the Indiana State Medical Association. These directors serve without salary, and are constantly endeavoring to fulfill the responsibility given them by the Indiana State Medical Association, in providing a plan that is equitable to the patient and the physician. Today nearly three quarters of a million Indiana residents are paying a large share of their doctor's bills through your own Blue Shield Plan. Since beginning the operation more than five million dollars have been paid to the physicians of Indiana through your Plan.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

March 18, 1951.

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; Alfred Ellison, M.D.; J. William Wright, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Membership Report

Number of members March 15, 1951	3,027
Number of members March 15, 1950	3,325
Loss over last year	298
Number of AMA members, March 15, 1951	2,411
Number of AMA members, Dec. 31, 1950	2,758

Treasurer's Office

On motion of Drs. Wright and Myers the Petty Cash Fund is to be increased from $500.00 to $1,000.00.

Statement of receipts and expenditures for January and February for THE JOURNAL was approved.

1950 Annual Session, French Lick, September 25, 26 and 27, 1950

Publicity. On motion of Drs. Ellison and Clark the executive secretary of the Indianapolis Medical Society was allowed $50.00 for handling press coverage during the French Lick meeting.

1951 Annual Session, Indianapolis, October 29, 30 and 31, 1951

Budget. It was taken by consent that the Budget Committee's action in reducing the budget of the Committee on Convention Arrangements from $6,000.00 to $4,000.00 be presented to the Council on April 29 for confirmation.

Honorarium for out-of-state guest speakers. On motion of Drs. Clark and Wright, the Committee approved the payment of a $50.00 honorarium to out-of-state speakers, in addition to their traveling expenses.

Program. On motion of Drs. Clark and Wright, the program of the Committee on Scientific Work was approved with the following changes:

a. The president's address will be delivered Tuesday night, October 30, instead of on Tuesday morning.
b. The American Medical Association is to be invited to supply a speaker on "The Importance of the Individual Doctor in Public Relations" during the twenty-minute period previously allowed to the president on Tuesday morning, October 30.

Fifty-Year Club reception. On motion of Drs. Clark and Kennedy, a reception is to be held on Wednesday afternoon, October 31, for members of the Fifty-Year Club.

Indiana Academy of General Practice luncheon. Approval was given the Indiana Academy of General Practice to hold a luncheon at the Athenaeum on Wednesday noon, October 31.

Banquet speakers. On motion of Drs. Kennedy and Clark it was left to the president to select the banquet speaker. The president announced his first choice would be Senator Mundt of South Dakota.

It was taken by consent that Dr. John W. Cline, who will be president of the American Medical Association by next October, be invited to deliver a fifteen-minute talk.

Legislative Matters

On motion of Drs. Kennedy and Clark the committee authorized the executive secretary to stop in Washington enroute to the A.M.A. meeting at Atlantic City next summer and call on Indiana's two senators and eleven congressmen.

Organization Matters

On motion of Drs. Clark and Wright, a letter which the Committee on Physician-Hospital Relationship proposes to send to hospital administrators and hospital trustees was approved.

Conference of Presidents. On motion of Drs. Clark and Kennedy the committee voted a 1951 membership in the Conference of Presidents at a cost of $50.00.

American Medical Education Foundation. Request of the American Medical Education Foundation for appointment of committees at the county and district level to solicit funds was tabled. The executive secretary was directed to notify the Foundation that THE JOURNAL is publicizing the fund-raising campaign.

Without motion, the committee recommended that the proposed statewide press-radio conference of the Committee on Public Relations be postponed until summer or fall.

VA fee schedule. The executive secretary submitted an amendment to the Veterans Administration fee schedule which had been signed by the chairman of the Committee on Veterans Affairs and Rehabilitation.

Membership plaques. On motion of Drs. Ellison and Clark the proposal of the Art Metals Company of Louisville that the headquarters office sell membership plaques was rejected.

Council on Mental Health. Consent was given the executive secretary to accept an appointment on the Council on Mental Health.

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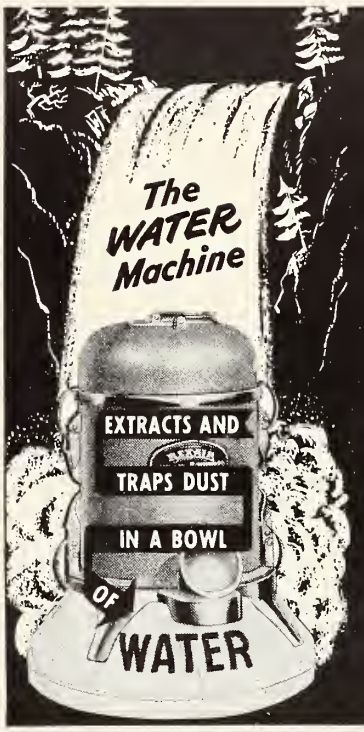
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Membership Matters

a. The committee approved the nomination of Drs. Kent and Culmer for Associate Fellowship in the American Medical Association, on motion of Drs. Clark and Wright.

b. *Remission of dues.* On motion of Drs. Clark and Kennedy, remission of dues was approved for those members whose names had been submitted to the headquarters office by various county medical society secretaries since the midwinter meeting of the Council.

c. *Senior membership.* On motion of Drs. Ellison and Clark, the committee voted to recommend to the Council that it rescind its previous action of not granting senior membership until the year after the member reaches the age of seventy-five and make it effective the year a member reaches the age of seventy-five.

On motion of Drs. Wright and Ellison, permission was granted Mr. Paul de Kruif to use excerpts from the published address of the 1948 president-elect of the Indiana State Medical Association which appeared in THE JOURNAL.

On motion of Drs. Ellison and Clark the committee voted to purchase the new Blue Cross-Blue Shield comprehensive hospital and surgical certificates for the lay employees of the headquarters office.

Following discussion by Albert Stump, on motion of Drs. Ellison and Clark the executive secretary was directed to notify the chairman of the Special Committee on Disability Insurance that no definite action shall be taken in approving disability health and accident policies until the matter can be considered fully by the Council at its next meeting.

Future Meetings

April 13, 14 and 15, 1951—Meeting of Board of Directors of Indiana State Chamber of Commerce, French Lick. On motion of Drs. Clark and Kennedy, the executive secretary was authorized to attend this meeting.

June 11 to 15, 1951—American Medical Association meeting, Atlantic City. On motion of Drs. Wright and Kennedy the committee voted against having an Indiana headquarters at the 1951 AMA meeting at Atlantic City.

November 6, 7 and 8, 1951—Conference of Physicians and Schools, Highland Park, Illinois. On motion of Drs. Ellison and Kennedy, the chairman of the 1951-52 Committee on School Health and Physical Education and the field secretary are to attend this meeting.

The Journal

Report on advertising:

Total advertising,	January	February	March
1950,	$2,183.17	$2,013.46	$2,099.88
1951,	$2,172.60	$2,121.21	$2,436.01

On motion of Drs. Clark and Kennedy the executive secretary's title was changed from "Managing Editor" to "Business Manager."

There being no further business, the committee adjourned to meet again on Saturday evening, April 28, 1951, at the Athenaeum, Indianapolis.

LOCAL SOCIETY REPORTS

Benton County Medical Society members had the auxiliary members as guests at dinner in the Country Club at Fowler, on March 15. At the election of officers Dr. Charles G. Smith of Otterbein, became president and Dr. Virgil Scheurich, of Oxford, secretary-treasurer.

Boone County Medical Society members met on March 6 for dinner and a business session at Witham hospital, Lebanon, followed by participation in the telephone seminar. A similar meeting on April 3 was attended by fifteen members.

Clay County Medical Society members heard a paper by Dr. L. L. Blum of Terre Haute, on "Practical Laboratory Procedures," at the meeting in the Elks club in Brazil, on March 19. Eleven members attended.

Cass County Medical Society members held election of officers at the meeting on March 16 in Logansport. Chosen were: Dr. Foss Schenck, president; Dr. L. J. Hillis, vice-president; Dr. Russell J. Morrical, secretary-treasurer. All are from Logansport.

Greene County Medical Society members met on March 15 at Linton, with nine members attending. A paper was read by Dr. William F. Craft of Linton, on "The Present and Past Flu Epidemics."

Howard County Medical Society members met on April 6 at the Francis Hotel, Kokomo, when Dr. Earl W. Mericle and Dr. C. Basil Fausset, of Indianapolis, discussed the medical and surgical treatment of mental diseases. Thirty members attended.

Jefferson County Medical Society members have chosen officers for the year as follows: Dr. M. W. Kemp, president; Dr. Wallace E. Childs, vice-president; Dr. Oscar A. Turner, secretary-treasurer. All are from Madison.

LaPorte County Medical Society members met on March 15 at Peacock Inn, Rolling Prairie for dinner and a program which featured a paper on "Uses and abuses of the anti-biotics," by Dr. George O'Brien of Loyola University, Chicago. Twenty-five attended.

Montgomery County Medical Society members met at Culver Union Hospital, Crawfordsville, on March 15 and witnessed a motion picture on "Here's Medicine—American Style," with twenty-four in attendance.

Parke-Vermillion County Medical Society members heard Dr. Robert E. Jenkins, of Indianapolis, speak on "Dermatoses of Hands and Feet," at the dinner meeting in Clinton Hospital on February 20. Fifteen were present. On March 21 there were eleven members present to hear Dr. L. H. Kornafel, of Indianapolis, speak on "Treatment of Thyroidism."

Vanderburgh County Medical Society members met in Hotel McCurdy at Evansville on April 10 to hear Dr. H. D. Bruner of the Oak Ridge Institute of Nuclear Studies, medical division, speak on the medical use of isotopes.

Vigo County Medical Society members and auxiliary met on March 14 for dinner and program at the Terre Haute House, in Terre Haute. Floyd E. Richards of Princeton, executive of the Devoe-Raynolds Company, explained his company's and community's experience with prepayment plans for health care.

St. Joseph County Medical Society members met on March 28 at Hotel LaSalle, South Bend, and heard Dr. Harris B. Schumacker, Jr., of Indianapolis, discuss the combination of medical and surgical treatment in the management of peripheral vascular diseases. About eighty members attended.

Whitley County Medical Society members met at the "30" Club, Columbia City, on March 13 and heard papers by Dr. Howard A. Stellner, of Fort Wayne, on "Post Encephalitic Behavior," and Dr. Lawerence Shinaberry of Fort Wayne on the American Association of Physicians and Surgeons. The twelve members present voted unanimously to include Dr. Paul Edward Kratz as a member of the society. He was licensed in Indiana in February this year, having previously practiced in Kansas City.





Prima Donna

Whatever your "role" in life, and the modern woman fills many, the eyes of the public are turned on you. Husband, employer, children and friends look at you every day. Do you give as much thought as you should to what they see? Some women have so many outside interests that they neglect themselves; others cling to beauty habits formed years ago. Our patrons obtain the maximum results with a minimum of effort through their Luzier Beauty Service . . . Spend an hour with the Luzier Cosmetic Consultant in your community. Plan a Beauty Program just for you. Then you can stand in the spot-light and face your audience with perfect confidence.

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Deaths

Earl Conover, M.D., of Evansville, died on March 25 at the age of seventy-two. A graduate of the University of Louisville School of Medicine in 1905, he practiced surgery in Evansville until he retired in 1947. Formerly he was an active member of the Vanderburgh County Medical Society, the Indiana State Medical Association and was a fellow of the American Medical Association.

Hubert Gros, M.D., of Delphi, died on April 1 at the age of forty-seven. He was graduated from the Indiana University School of Medicine in 1928 and interned in hospitals at Indianapolis, Chicago and Pittsburgh, and held a residency for one year at the American Hospital in Paris, France, and later at Culver Military Academy hospital. He enlisted in January 1941, serving the Medical Corps in Camp Knox, Ky., and in California, and in Burma, India. He was a member of the Carrol County Medical Society, the Indiana State Medical Association and was a fellow of the American Medical Association.

Alvin R. Kerr, M.D., of Attica, died on March 11 at the age of sixty-nine, at the Veterans Hospital in Indianapolis, following several weeks' Illness. Graduated from the Indiana University School of Medicine in 1910, he practiced at Mellott for a short time before locating in Attica, specializing in ophthalmology and otolaryngology. He was a member of the Fountain-Warren County Medical Society, the Indiana State Medical Association and the American Medical Association.

Russell Rollins, M.D., of Royal Center, died on March 31 at the age of fifty-six. He was a graduate of the Indiana University School of Medicine in 1936, and had practiced in Royal Center for fourteen years. He was a member and former president of the Cass County Medical Society, member of Indiana State Medical Association and fellow of the American Medical Association.

J. G. L. Myers, M.D., of Bloomingdale, died on April 1 at the age of ninety-three. He had retired a number of years ago, after more than fifty years of active medical service.

Ralph B. Lingeman, M.D., of Rochester, New York, died on April 7 in San Antonio. He was fifty-four years of age. He was a graduate of Indiana University School of Medicine, in 1923, and had practiced in Indiana, Florida, New York and Texas. He was a veteran of World War II.

Head Pain as a Diagnostic Lead

Frequently the presence of head pain is overlooked. The physician learns of it only if he has made an effort to elicit the information. Since the etiology of the pain is the basis of rational management, the patient should be warned against taking medication before diagnosis is made.

Friedman[1] deplores the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache — its character, laterality, frequency and intensity.[2]

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic, analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain not related to b.p. level; Dihydroergotamine. relieves pain.	General hypertension therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g-i. upset during headache.	To abort attack: oral ergotamine plus caffeine. General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,[3] and Friedman, A. P.[4]

Cecil[5] ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

1) Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.

2) Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.[1,6] *The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.*

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 54:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563; Saunders Co., Phila. 5 Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOKS RECEIVED

METHODS IN MEDICINE of George Dock, M.D. By George R. Herrmann, M.D., professor of Medicine, University of Texas Medical Branch, Galveston, Texas. Second edition. 488 pages. Price $7.50. The C. V. Mosby Company, 3207 Washington Blvd., St Louis, 1950.

TREPHINE TECHNIQUE OF BONE MARROW INFUSIONS AND TISSUE BIOPSIES. By Henry Turkel, M.D., 650 Boston Boulevard, Detroit 2. Fourth Edition. 60 pages, and approximately 25 illustrations. Copyright 1950 by author. Copies may be obtained at $1.00 each from Trephine Instruments Inc., 1301 Industrial Bank Bldg., Detroit 26.

ACTA OTO-LARYNGOLOGICA. By Moe Bergman, ED.D., Chief Audiologist, Audiology Clinic, New York Regional Office, Veterans Administration, New York City. 107 pages and 18 illustrations. Published and copyrighted 1950 by Acta Oto-Laryngologica, Vapnaregatan 6, Stockholm. Copies available at $1.00 each from Audiology Foundation, 1104 South Wabash Avenue, Chicago 5.

FUNCTIONAL ANATOMY OF THE LIMBS AND BACK. By W. Henry Hollinshead, A.B., M.S., Ph.D., Head of Section on Anatomy, Mayo Clinic, Rochester; Professor of Anatomy, Mayo Foundation, University of Minnesota. 341 pages with 122 figures. Price $6.00, W. B. Saunders Company, West Washington Square, Philadelphia 5, 1951.

THE SCIENCE OF HEALTH—Second Edition. By Florence L. Meredith, M.D., Fellow of the American Medical, American Public Health and American Psychiatric Associations. 450 pages; 48 tables and charts; 134 illustrations. Price $3.75. The Blakiston Company, Philadelphia 5, 1951.

CHILD PSYCHIATRY IN THE COMMUNITY. By Harold A. Greenberg, M.D., senior staff psychiatrist, Institute for Juvenile Research, Chicago. 296 pages. Price $3.50. G. P. Putnam's Sons, 2 West 45th Street, New York City, 1950.

TEACHING THE RETARDED CHILD AT HOME. By Edna Davison Osterhout, B.A., Brett School, Dingman's Ferry, Pa. 67 pages. Price $2.25. Duke University Press, Durham, N. C., 1950.

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BOOKS REVIEWED

THE RHESUS DANGER, ITS MEDICAL, MORAL AND LEGAL ASPECTS. By R. N. C. McCurdy, M.B., Ch.B., D.P.H. 138 pages. Price 5 shillings. William Heinemann Medical Books Ltd., 99 Great Russell Street, London, 1950.

This little volume is the ideal book for the general practitioner and his medical confreres whose interest in the Rh factor and its problems are of a general and not a technical nature. The text is divided into two sections. The first section deals with the medical and scientific aspects of the subject, including a pleasantly non-technical discussion of the historical background of not only the Rh factor, but also the related subjects of inheritance of characteristics, blood groups, and blood transfusions. The second part of the book deals with "Some of the Wider Issues" arising from what the author calls "The Rhesus Problem." It will, no doubt, be a surprise to many readers that some of these "wider issues" are so wide, but the author makes a strong plea for greater understanding of the many problems which are constantly arising because of the Rh factor.

The last chapter consists of a selection of the more basic bibliographic references to articles and books on the Rh factor and related subjects. And, finally, there is an index, which even in such a slim volume, makes it much more usable as a ready reference source.

LALL G. MONTGOMERY, M.D.
PATHOLOGIST.

CEREBRAL PALSY. By John F. Pohl, M.D., orthopedic surgeon, Michael Dowling School for Crippled Children, Minneapolis. 224 pages with 131 illustrations. Price $5.00. Bruce Publishing Company, 2642 University Ave., St. Paul 4, Minnesota, 1950.

This book, written by an orthopedist who has spent 12 years in the study of cerebral palsy, will be invaluable to the physician who treats this condition. The author covers all phases of therapy and devotes four entire chapters to neuromuscular training.

One hundred thirty-one photographic illustrations and drawings supplement the descriptive chapters and vividly demonstrate each step to be taken in the treatment of all types of cerebral palsy.

This book is a valuable reference book for the physician as well as the physiotherapist. The parents of a patient with cerebral palsy will also get valuable information from this text, as well.

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From The Literature
- Bubert and Cook, Bulletin of School of Medicine, Univ. of Maryland, Vol. 32, pp. 175-190, 1948.
- Paul and Montgomery, J. Iowa State Med. Soc., June, 1948.
- Krantz, Holbert, Iwamoto and Carr, J.A.Ph.A., Vol. 36, pp. 248-250, 1947.
- New and Non-official Remedies, 1950, p. 285.

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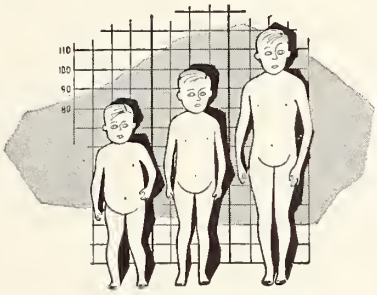
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THE Indianapolis Medical Society has been active in civil defense because its membership recognizes the need for action. With great effort this society, through its Civilian Defense Committee, has evolved a plan of action in case there be need. Our members have given unhesitatingly of time and money to do this job.

Inasmuch as a large proportion of these society members have had military experience, there is no difficulty in enlisting their support. We realize that such an organization may never be needed, but we also realize the chaos that would result if disaster struck and we were not ready for it.

We feel that our effort is timely and we have had the congratulations of Mayor Philip Bayt for being the leaders in this preparation. This is another example of the benefits that result from the action of organized medicine. Without the parent organization of the local medical society this action would not have been possible, proving this an example of democracy in action, which indicates that democracy can be effective when proper leadership is available.

The society is indebted to all the members of the committee, and particularly to Dr. E. Vernon Hahn and Dr. Okla W. Sicks. As has been evident throughout the United States, the medical preparedness for this situation leads in Indianapolis.

EARL W. MERICLE, M.D., *President,*
Indianapolis Medical Society.

THE IMPACT OF CIVIL DEFENSE UPON THE MEDICAL PROFESSION

NOT SINCE the War of 1812 has there been a real threat of attack upon our shores and the citizens of this country and our state. Atomic weapons have changed this sense of security and complacency. Russia has atomic bombs. It has bombers capable of delivering these bombs. Military authorities state that it is a matter of six to eight hours from air bases in Siberia to the cities of Indiana. Leaders in our air force assert that more than half of such bombers would elude our defenses and reach their targets.

We are dealing, therefore, with stark reality, not with just visionary dreams or imaginary probabilities. It is true that we may never experience such an attack. We hope and pray such will never happen. As long as the potentiality exists, we must plan for the worst and hope for the best.

Planning for atomic, biological, and chemical warfare has been likened to the purchaser of fire insurance on his home. It is hoped a fire never destroys his home, but if it does the owner is prepared—at least for financial losses suffered.

So must we prepare for every eventuality to protect as far as possible our families, our friends, and the people of Indiana. This preparedness will cost money and the services and time of many people. The lives of thousands of people will be saved by such preparation, as well as enabling us to continue the fight against the enemy. The cost of planning in this eventuality will be extremely small. If the attack never occurs, we will have gained much valuable training and knowledge, and have the additional thought that perhaps our preparedness had some effect in discouraging the attack.

Civil defense cannot be thought of as an emergency measure of one or two years' duration. It is a process involved in our changing civilization, whether we like it or not, and will affect all our lives for years to come.

Civil defense is a task for civilians and their civil governments. Volunteers from every segment of American life must accept responsibilities in this program.

The medical and allied professions have a most vital role to play in civil defense. Atomic, biologic, and chemical warfare produce no new or mysterious illnesses. The medical profession has been familiar for many years with the effects of ionizing radiation on the body, the preventive aspects of epidemic disease, and the medical phases of chemical warfare. The problem presented to us is one of logistics, a race against time to get sufficient trained personnel and supplies to any of several different points of attack within the state to care for thousands of casualties.

To be most effective, planning for health services must be fully coordinated with other civil defense services. We are dependent upon transportation for the movement of personnel, supplies, and casualties. Hospitals would be unduly crippled without emergency electrical and water services provided by engineers.

The same spirit of planning together and working together must prevail within the health services. Arrangements for medical care, improvised hospitals, laboratory and blood services, contagious disease control, biological warfare, and radiologic monitoring are essential functions of health services and must be planned together from the start.

It is suggested that whatever we do, we do together, recognizing the training, skills, and experiences of each profession. Having had the privilege of working with Hoosier physicians for the past six years, I have the utmost confidence in their resourcefulness, their unselfishness, and their ability to discharge their responsibilities effectively.

L. E. BURNEY, M.D., *Director*
Health Services Division
Indiana Department of Civil Defense

NATIONAL SURVIVAL UNDER ATOMIC ATTACK

E. Vernon Hahn, M.D.*

INDIANAPOLIS

AUTHORITIES state that Russia is presently able to drop an atom bomb on any chosen target in the United States except in the extreme southeastern part of the continent.

Several cities could be bombed almost simultaneously and more than one bomb could be dropped on any one of the accessible targets.

It is said that defensive interceptor planes could not prevent four-fifths of an invading air armada from reaching goals satisfactory to the enemy.

It is impossible to provide for this country a radar screen which can guarantee the detection of all high altitude invading aircraft. Anyway, even hours of warning would not greatly reduce the number of casualties because predisaster evacuation of urban populations is impracticable.

A single Hiroshima type bomb ("nominal bomb") would produce 120,000 casualties if dropped over the congested area of any large city.

Only 20,000 of these casualties can be figured as presenting minor injuries. Of the 100,000 seriously injured, 40,000 would be dead at the end of the first day. The remaining 60,000 would constitute a serious treatment problem which would grow less week by week, as recoveries were accomplished and as delayed deaths occurred.

Of the 100,000 seriously injured living casualties, 15,000 would suffer from nuclear radiation; 20,000 from burns; 65,000 from mechanical violence.

The physical effects from mechanical violence would include lacerations and contusions of soft parts resulting from the terrific blast, penetrating wounds from flying glass, laryngeal injuries from inhalation of hot gases, chest crushes and penetrating wounds, brain injuries, eviscerations, and fractures of the skeletal structures.

In proportion as predisaster tetanus immunization is neglected, deaths from that infection would number thousands since supplies of antitetanic serum for prophylaxis and for treatment would not be a "drop in the bucket."

In comparison with the terrible toll of life and the enormous incapacitation from serious injuries sketched in the foregoing, damage to industrial equipment would be slight and unimportant. Most of our machinery could be readied for production in a short time to the end that we could strike back at the enemy.

This, then, is the high purpose of Civil Defense—to minimize loss of life and human energy so that we may survive as a nation.

Defeatist notions of abandonment of cities like Indianapolis, of large scale evacuation of the injured to distant cities, and of dependence upon some mythical elsewhere-agency are imbecilic and have been rejected entirely by the Committee for Civil Defense of the Indianapolis Medical Society.

Nevertheless, no city could possibly cope with the consequences of an atom bombing without assistance from a surrounding support area. The self-reliance which is advocated herein is the self-reliance of a target city and its surrounding 100 mile wide target area which could not avoid a huge share of the general affliction. The cities, towns and country people around Indianapolis would not be merely sympathetic witnesses of awful destruction and suffering. They would find themselves obliged by common humanity to afford sustenance and shelter to thousands of orphans and homeless until the able-bodied survivors remaining in the city could effect a degree of rehabilitation. Thousands of seriously wounded and victims of radiation sickness would be dropped on the doorstep of every hospital within a radius of fifty or more miles. There would be no other way. Even if poor marksmanship should miraculously permit the survival of hospitals within Indianapolis, they could not cope with the enormous case-load.

In extending care to disaster victims of Indianapolis, the surrounding towns would themselves require help. Therefore the civil defense plan for Indianapolis provides for the dispatch of surgeons and consultants, as well as of other supporting services, to the towns in the Central Indiana disaster region. The Indiana Civil Defense Act of 1951 provides for mutual aid pacts among the counties, and the civil defense directors of the target counties will be forced by the logic of the situation to establish relations with the directors of the counties and/or cities of the surrounding support zones.

The Civil Defense Committee of the Indianapolis Medical Society anticipated this necessity early in its planning, and the medical societies of the seven immediately adjacent counties months ago pledged their participation in the mutual defense effort.

But the civil defense of the Central Indiana region cannot stand alone. Our state includes four other primary target areas. An atom bomb disaster in any one of them would, in one way or another, endanger the security of every hamlet in Indiana. Our mutual dependence for food, markets, services, and protection against disease (including the possible consequences of biologic war-

*Director of the Medical Division of the Marion County Civil Defense, and Co-chairman of the Civil Defense Committee of the Indianapolis Medical Society.

fare) is such that civil defense is the common problem of the entire state. The integration of the five regional patterns is the special province of the state civil defense organization and is presently being carried forward by the Director of the Health Services Division thereof, Dr. Leroy E. Burney, and his staff.

The intricate logistics of the civil defense problem created by the special destructiveness of atomic bombing will become more evident with study of the detailed plans elaborated by the Civil Defense Committee of the Indianapolis Medical Society, which was charged with that responsibility by my predecessor as Director of the Medical Division of the Marion County Civil Defense, Dr. Charles W. Myers. The employment of medical societies for the preparation of local civil defense plans was recommended by the Federal Civil Defense Administration and has become almost a universal pattern. Doubtless one reason for this is that the aim and effect of atomic warfare is paralysis of industry *by wholesale incapacitation of personnel.* Thus, the crux of civil defense in this atomic age is *medical* relief. The medical resources of Marion County were so well commanded by Doctor Myers that no rearrangement has been occasioned by his much-regretted resignation.

Particular recognition should be given here of the overall planning of Mr. Charles R. Broderick, Civil Defense Director of Marion County. He and the directors of the nonmedical divisions have lent every assistance to the medical division. It must also be stated that without the assistance of Mr. Virgil Sheppard of the American Red Cross the plans of the Medical Society would have lacked concreteness and would have remained in that nebulous state of "just talk" which seems generally to have afflicted the civil defense movement.

Finally, the highest praise must be accorded those groups upon which the medical profession relies for the accomplishment of even its ordinary jobs. The dentists, nurses, medical technicians, and druggists have all shown their devotion to the cause of relieving suffering and saving lives. Their response to the tireless leadership of Dr. Okla W. Sicks, Co-chairman of the Civil Defense Committee of the Medical Society, has been magnificent. Equally inspiring has been the response of the lay medical corpsmen to the leadership of Dr. Harrison Green, and of the Red Cross first-aid trainees to that of Mrs. Walter P. Morton.

GOVERNOR PRAISES MEDICINE FOR ITS ROLE IN CIVIL DEFENSE

Since the beginning of our civil defense efforts in Indiana, we have received wholehearted cooperation from members of the medical profession. The issuance by THE JOURNAL of the Indiana State Medical Association of a Civil Defense number is a concrete example of medicine's interest in this subject.

Without the scientific know-how of the doctor, our planning for care of casualties in event of atomic bombing would be useless. As a matter of fact, it would be virtually futile. Therefore, it is heartening to us who are administratively responsible for perfecting the civil defense program to have the help and advice of our Indiana physicians.

All of us are particularly proud of the progress Marion County has made in civil defense. I doubt if any community of similar size in the United States has set up an organization that is as thorough and workable. A large measure of credit is due to Indianapolis physicians who have given unselfishly of their time and talents in this public service. The Marion County Civil Defense organization, so I am told, bids to become a model for the nation.

I take genuine pleasure in making public acknowledgment of the medical profession's contribution to our civil defense efforts and in expressing the appreciation of a grateful citizenry for medicine's leadership in this humanitarian undertaking.

HENRY F. SCHRICKER, *Governor.*

ASSOCIATED SERVICES DIVISION

Okla W. Sicks, M.D.*

INDIANAPOLIS

DURING the process of planning for the medical phases of civil defense in Marion County, the volunteer spirit and enthusiasm of all groups with which the medical society committee has had contact has been outstanding.

The nonmedical professional groups have all been prime examples of public-spirited devotion to duty, and have cooperated to the fullest extent in the formulation of plans. Personnel of the allied professions have given freely of their time and have eagerly sought assignment to treatment stations for duty in case of disaster.

Two hundred fifteen dentists and 45 dental assistants have volunteered for work on treatment teams. They have been organized under the direction of Harry Nagle, D.D.S., Dental Director of Civil Defense of Marion County. They are assigned to treatment stations as near to their homes and offices as possible. The dental personnel of each sector is further organized under a sector captain. They will care for casualties who have injuries of a dental nature.

Harrison Green, M.D., Director of the Lay Medical Rescue Corps, is supervising the training of, and organizing teams of laymen who will enter the casualty belt and remove the casualties to treatment stations. These people are formed into teams of about 9 rescue workers to each 1,000 population.

The registered nurses of Marion County and the immediate surrounding territory have been organized by the leadership of Mrs. Genevieve Beghtel, R.N., President of the Central District of the Indiana Nurses Association. They constitute a very enthusiastic group of 1350 active members and about 2000 inactive members. They have all been given assignments to medical treatment stations, based upon their specialties and the location of their homes. The active nurses hold a primary assignment at their regular peacetime post of duty, and a secondary assignment at a disaster treatment station in case their primary post is rendered inoperative.

The members of The Indianapolis Society of Medical Technologists, under Miss Rachel Lehman as their Civil Defense Director, are prepared to assist in the conduct of improvised and temporary hospitals, in the event that their regular laboratory and hospital facilities are destroyed. There are over 120 of these highly trained persons. Their assistance will be very valuable in the performance of all types of laboratory procedures, but particularly in the examination of blood specimens.

The pharmacists of Marion County have not only volunteered for emergency duty in medical treatment stations but have also devised a plan to insure a well dispersed source of medical supply. With the leadership of Mr. Albert C. Fritz, Secretary of the Indianapolis Pharmaceutical Association, they have agreed to maintain in each of 250 drug stores, a rotating stock of essential drugs and antibiotics. Each store will maintain a stock of at least $100 worth of drugs and antibiotics which will be kept up-to-date by use and replenishment. They will be packed in containers which will permit of easy transport to treatment stations.

Mr. Harry Moore, Civil Defense Director of Vital Statistics and Morgues of Central Indiana, has organized the funeral directors and their staffs. This group has two very essential duties to perform in case of a large disaster. One is the identification of the dead—a necessity from the legal and insurance viewpoint; and the other, disposal of the masses of dead—an emergency from the standpoint of health and sanitation. Mr. Moore has 100 licensed and 75 student apprentice embalmers and would expect help from surrounding cities in carrying out this tremendous task.

The American Red Cross has been conducting classes in home nursing under the direction of Mrs. Walter P. Morton. Eight classes are in progress at all times and 750 trained personnel are now available. These trainees will be invaluable in caring for many thousands of wounded.

Mr. Irving Ruben is Director of Ambulance Services for Civil Defense. He has received very hearty cooperation from business firms of Indianapolis who have vehicles suitable for, or which can easily be made suitable for transportation of casualties. Ninety ambulances and 300 vehicles adaptable for improvised ambulances will be equipped with stretchers and other equipment for quick transformation in case of catastrophe.

*Co-chairman of the Civil Defense Committee of the Indianapolis Medical Society.

PUBLIC HEALTH DIVISION OF THE MEDICAL SERVICES

Gerald F. Kempf, M.D.*

INDIANAPOLIS

THE functions of the public health division may be divided into predisaster work and that necessary after disaster. The predisaster work, in addition to planning for postdisaster work, includes working toward a high immunization rate against communicable diseases and a high degree of community sanitation. The Marion County Medical Civil Defense Committee of the Medical Society and the health department are presently carrying out a program of active immunization against tetanus in which all physicians have been asked to participate. Typhoid immunization is also recommended. The community sanitation division of the department is presently engaged in checking the selected medical and other stations for emergency and regular disposal of wastes which will be extremely important to maintaining the emergency services during a disaster.

The medical profession and all sources of information regarding illness such as industries, and the school health, sanitation, water, food, milk and meat inspection services, are on the alert for anything unusual in illnesses of people and animals that might lead to the detection of chemical or bacteriological sabotage within this area. Water and food supplies are receiving regular checkups. In our planning our division is maintaining a liaison with the planning of the entire medical division, power, water, food, engineering, transportation, and communication and the schools wherever their functions are in any way related to environmental sanitation and preventive medicine.

The health department is working with the coroner's office, the funeral directors, the cemetery association and the clergy in planning for the burial of the dead. Fortunately plans for uniform indestructible tags for identification are in the overall plans. Without these, identification of the dead and even many of the injured will be an almost insurmountable obstacle. Teams of funeral directors and their helpers will be assigned to selected morgues easily available to treatment stations and the disaster area for the processing of the dead sent to them. An easily attachable nonmetal tag upon which the location where found may be marked, along with the assignment of a destination for information of those transporting the dead and injured, will be necessary. A portion of the tag will go with the person's effects for identification for the coroner and for the vital records and a last part will remain with the body as the cemetery's permit for burial.

The coroner has plans for a liaison with a committee from the banks to provide disposition for the records of valuables and identification. If metal tags are worn these will remain with the bodies for marking them and the location of burial. The cemeteries are planning for mass burials to care for 50,000 or more dead within a period of five days. They will keep records and locations of the burial of both identified and unidentified dead. They will look to engineering transportation and equipment committees for assignment of digging equipment for mass burial. All of this will be done in such a manner that later removal to family plots may be accomplished. Obviously this is an essential service for the protection of the living because of the sanitation problems that would secondarily arise from the dead alone. This whole procedure is essential for the legal establishment of records of death for the settlement of estates and other affairs that will affect the survivors.

All health department personnel including doctors, nurses, sanitarians and laboratory personnel will be expected to carry out their normal functions with the help of those sent in by the State Board of Health to replace those lost and to augment the work of the staff in carrying the increased load. Obviously each person will receive a number of predetermined assignments designated as first, second and third to adapt our services to varying locations of ground zero and to care for areas left uncovered by those lost. This personnel, especially our nurses, are expected to fit themselves into any of the medical teams if the exigencies of the situation and the destruction so demand.

In the event of a disaster the environmental sanitation section of the department of public health would be concerned with (1) the safety, quality and quantity of any and all water supplies, (2) the services available for the disposal of wastes and the methods used in securing proper disposal of these materials, (3) the availability of food, drugs and milk supplies, (4) the extent to which such supplies are or may be contaminated biologically, chemically and radiologically, (5) the means and methods used to check normal and emergency supplies to determine their safety for human consumption, and (6) the control of rodent and insect population and other animals within the disaster area.

The health department is responsible for assisting in educating the general public regarding the necessity of providing emergency facilities in each home so that each householder would have stored in his basement sufficient food and water supplies to last for at least two or three days. The public is to be advised in the matter of waste disposal as

* Director Public Health, Indianapolis Department of Public Health, and Director, Public Health Services, Marion County Civil Defense Organization.

each home may have to provide means of properly disposing of their own wastes on their own premises at least for a temporary period. The seriousness of exposing wastes to insects and rodents must be impressed on each citizen.

Health department personnel will be used to check emergency water supplies and to so treat such supplies as may be available so as to make them fit for human consumption. The actual repair of the public distribution system would not come within the province of the health department but the safety of the supply must be assured by the health department. There is always the possibility that a public water supply may be contaminated, chemically, biologically or by induced radioactivity. Such supplies would have to be decontaminated or their use prohibited. It would be the dutv of the health department to perform or supervise these activities. It may even be necessary for the department to secure emergency pumps and other material for use in storing or distributing water in certain areas. The health department must secure chemicals and assist in the chemical treatment of emergency water supplies. Chlorine tablets have been placed in all schools, and materials for larger scale chlorination of drinking water are provided. In the matter of food and drugs, existing supplies will be examined to determine the type and extent of contamination. All emergency supplies will be checked or information secured as to their source and quality. The consuming public must be impressed with the necessity of using only food and drugs that have been approved for use by the proper authorities.

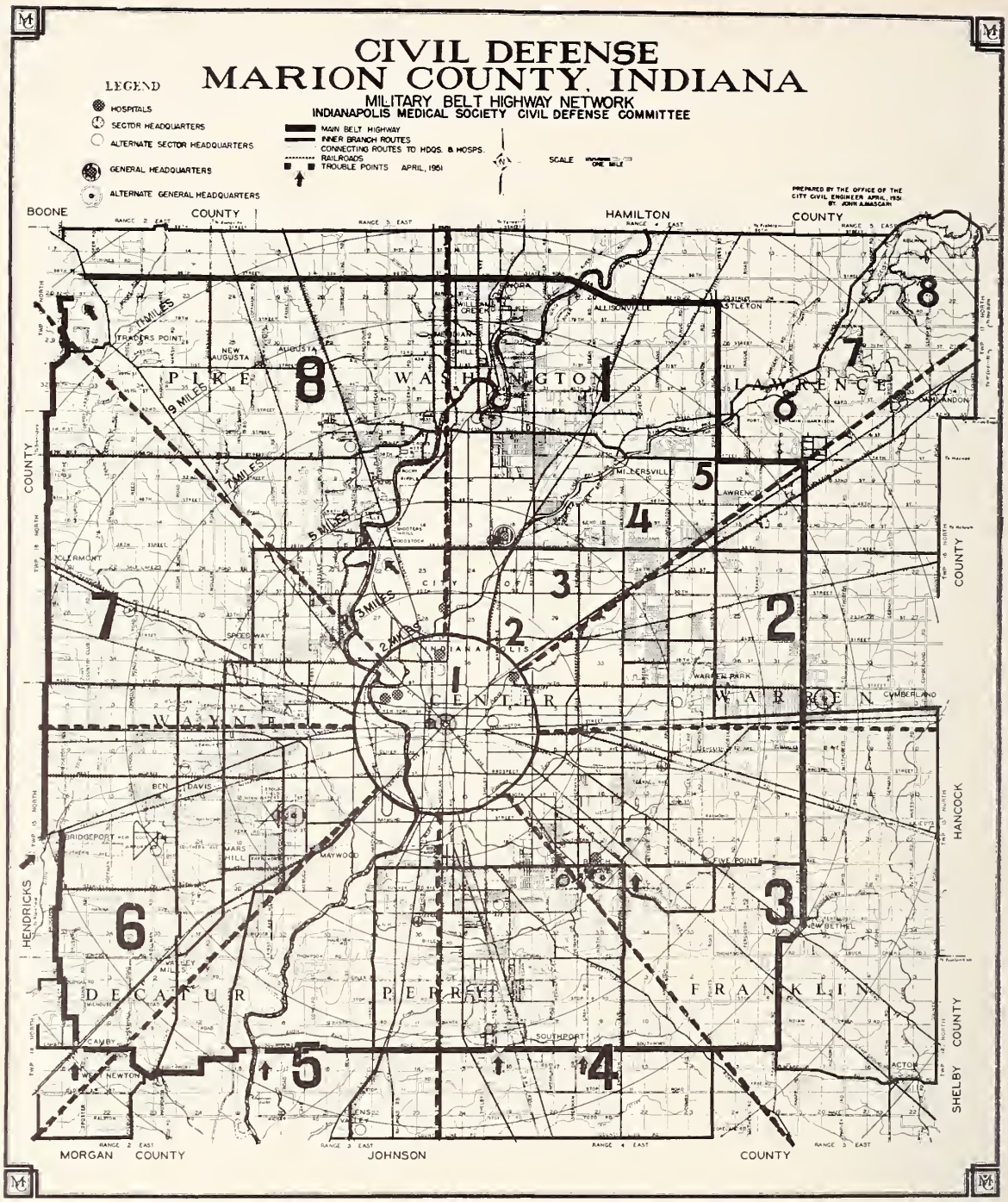
It will come within the province of the health department to secure emergency milk supplies outside the normal procurement area, if the local supply is not available. The processing of milk will be checked as is normally done now not only in regular plants but in any emergency plants. Certain information must be secured as to the production and distribution facilities of emergency supplies before their use can be authorized.

Health department personnel will be needed to check all wastes and refuse disposal facilities available. Emergency methods will be necessary in some instances. Equipment for trench digging and transportation of refuse must be available. In outlying evacuation centers much of this can be supplied from farm equipment. Education of the citizens as to how they can best take care of their own wastes should be done before disaster strikes. Emergency medical and housing centers will be checked and assistance given in securing the necessary supplies. Disaster areas will be policed by trained personnel in order to prevent the use of questionable food and water supplies and the improper disposal of waste matter. Survey of the area will be made to determine the extent of rodent and insect infestation. The control of these pests in bombed areas will involve the use of health department personnel working in cooperation with pest control operators. Certain sections will be sprayed or fogged with insecticides. Baiting to control the rat population will be done by trained personnel.

It can be readily surmised that the normal staff of the local health department will be insufficient to cope with the numerous problems arising from a disaster. Arrangements are being made with the State Health Department to secure trained personnel from the state staff and from other local health departments to team with our own staff in event of disaster. We are asking for enough temporary help to double our regular staff in sanitation, water and food work. Trained personnel from the food, drug and milk industries will be available for use. The veterinarians, through their organization, will be available to check meat supplies and particularly animals that may be slaughtered under emergency conditions. A close liaison must be maintained between the health personnel working with food supplies and the radiological section since the extent and intensity of radiological contamination must be determined immediately and food in contaminated areas will have to be salvaged or destroyed by burying in deep trenches. The decontamination of food and buildings will be a tremendous task. It is sometimes advisable to destroy rather than decontaminate. Large stocks of food may be contaminated with bomb debris only on the outside. In that case personnel properly clothed could remove the contaminated goods and the remainder of the supply released for use. Gamma rays from an atomic blast are of such short duration that they are of little or no significance. Radioactive bomb dust containing alpha particles may contaminate food supplies to a serious extent. The intensity of such contamination must be determined through the use of an ionization chamber and not a Geiger counter. Slight contamination may be removed by thorough washing. Since the half life of some particles is very long, mere storage of the contaminated goods will not reduce the danger. When the half life is short, storage will suffice to render the contaminated material safe for use.

Special training of experienced sanitarians is necessary to acquaint them with the emergency procedures and methods likely to be used. They must be familiar with the various types of contamination that may be encountered, and the means of coping with these problems. Most of their work will be the same as their usual routine activity except that it will be intensified.

Control of the environmental sanitation factors in a disaster area will prevent the spread of contagious diseases and its subsequent burden on the medical section of the emergency organization. This control will be facilitated by an intensified educational effort to inform the citizens of the importance of environmental sanitation and the part they should play in preventing the spread of disease. "An informed citizenry is a strong defense," holds for all of the work of all divisions of civil defense.



This map emphasizes the existing roads and streets upon which the Executive Division of the Civil Defense Committee of the Medical Society might have to depend for maintaining communication with Treatment Stations in event of a centrally placed bomb hit. The map indicates the streets which provide the most direct routes to the various Sector Headquarters from the peripheral belt "highway." Each officer of the organization will be provided with an unredacted edition of the map for possible use in supplementing services planned by the Divisions of Transportation and Communication.

Since preparation of this map the State Highway Commission has announced plans for new construction which would greatly improve the western side of the belt "highway."

REGIONAL ORGANIZATION OF MEDICAL CIVIL DEFENSE

GENERAL CONSIDERATIONS

1. Indianapolis is practically flat. Its terrain provides no natural barriers to the centrifugal spread of nuclear radiation, radiant heat, or blast from an atomic explosion. A bomb detonated at optimum altitude would thus inflict in all directions the maximum damage for the size of bomb employed.

2. Ninety percent of the city's population and industrial establishments lie within a circle 14 miles in diameter. This area is not subdivided into regions by natural features of terrain. Subdivision, for planning of tactical operations as well as for analysis of resources on a regional basis, must therefore be arbitrary. It seemed logical to establish eight triangular sectors, fanning out from the geographical center of the city, and a series of concentric zones, centered likewise. (See map.)

3. From northeast to southwest the city is traversed by White River which, with its tributary Fall Creek would constitute a serious barrier to the flow of traffic. Even though bridges should withstand atomic attack with little damage, as in Hiroshima, they would probably constitute bottle-necks because of their inadequate number. These facts necessarily influenced the choice of locations for treatment stations and the assignment of personnel.

DISPOSITION OF PERSONNEL

4. The extreme centralization of business in Indianapolis introduces a serious difficulty in planning for disaster. About 400 doctors maintain offices within a central circle one-half mile in diameter. Another difficulty grows out of the fact that 90 percent of the doctors have chosen to reside in Zones 3 and 4 of Sectors 1 and 2. Therefore the assignment of doctors and associated personnel to stations in the South and West Sectors had to be partly by lot and without any immediately evident logicality. The following principles, however, were followed in so far as possible: (a) in anticipation of possible night attack, and also for psychologic reasons, an attempt was made to assign doctors to stations not too far from their homes; (b) shifts of doctors from one sector to another were planned by short jumps around the periphery rather than by cross-town moves; (c) doctors whose practice had been for years in one quarter of town were assigned to stations in that territory even though getting there from a distant residence might pose a difficult problem.

5. High density of population extending far out toward the periphery in Sector 1 required establishment of a large number of treatment stations and assignment of a large number of doctors. However, the disproportion, relative to other sectors, under actual conditions of a day-time atomic disaster would likely vanish, since mortality and disablement would run high among these doctors, many of whose offices are in Zone 1.

6. The unpredictability of "ground zero" and of conditions which would actually prevail in event of attack requires that predisaster disposition of personnel be regarded as highly provisional. Redeployment at the time of disaster must be contemplated. In fact, a series of shifts would certainly be required as first aid services were gradually accomplished. Nevertheless, if predisaster assignments are complied with, in so far as feasible at the time, the Executive Committee will have some more or less dependable knowledge of where to find doctors and their associated personnel.

7. Predisaster assignment of (a) dentists, (b) nurses, (c) pharmacists, (d) lay medical rescue corpsmen, (e) Red Cross first aid trainees, (f) morticians, (g) podiatrists, (h) ambulances and ambulance-trucks, and (i) emergency messengers including mounted messengers from the Indiana Saddle Association, will be in accordance with the master plan of medical stations.

8. Physicians who are not members of the Indianapolis Medical Society and Doctors of Osteopathy, who have volunteered for service, have been distributed impartially among the stations.

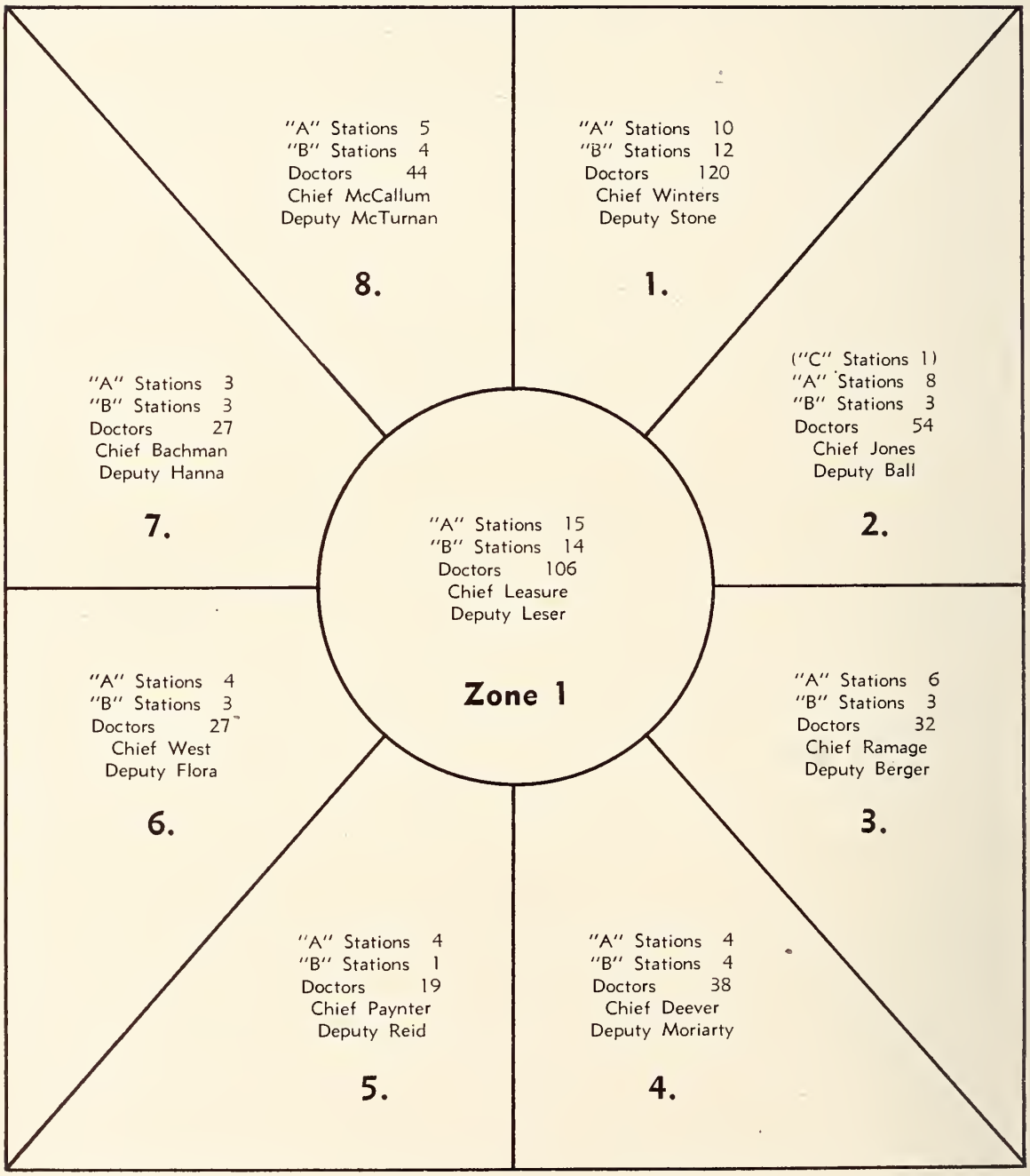
9. A representation of the specialties was provided to each sector. However, a full complement of specialists could not be assigned to a single station. It is expected that each doctor study the assignments for his sector so that he may know where various specialists might be found and act accordingly in dispatching casualties.

10. Appointment to Captaincy or Sector Chiefship was based primarily on the circumstance of location of office and residence in the hope of providing officers with superior expectancy of survival and ability to mount their posts of duty. Doctors of advanced age and those requesting light assignment because of poor health were not asked to serve as officers. For these reasons, it must *not* be assumed that designation as an officer reflects anyone's opinion concerning superiority of professional ability or prestige.

11. It is obviously impossible to provide a complete roster of all personnel assignments to all concerned. However, each member of the Executive Committee will have such a roster. A complete list of all the doctor assignments cannot be supplied even to the doctors. In fact, this list is held as "classified" open to inspection only to members of the Indianapolis Medical Society. However, it will be possible to provide each Sector Chief and

SECTORS—SECTOR OFFICERS—RECAPITULATION OF STATIONS

SECTOR CHIEFS	SECTOR	DEPUTY CHIEFS
Matthew Winters, M.D.	1	A. T. Stone, M.D.
Francis P. Jones, M.D..	2	Joseph E. Ball, M.D.
Walter F. Ramage M.D.	3	Morley Berger, M.D.
John W. Deever, M.D.	4	John R. Moriarty, M.D.
Morris B. Paynter, M.D.	5	Charles A. Reid, M.D.
Joseph L. West, M.D.	6	Joseph O. Flora, M.D.
Arnold J. Bachman, M.D.	7	Thomas A. Hanna, M.D.
J. T. C. McCallum, M.D.	8	Robert W. McTurnan, M.D.
J. Kent Leasure, M.D.	Zone 1	Ralph U. Leser, M.D.



Deputy Sector Chief with a list of all assignments in their sector; and each Captain and Deputy Captain with a list of all their team members.

12. The Indiana Bell Telephone Company is preparing under the direction of Colonel Foster Stanley, a special Civil Defense Directory of the phone numbers of all key personnel. This directory will be published in quantity, permitting wide distribution.

TREATMENT STATIONS

1. "A" Stations

"A" Treatment Stations are planned to operate as the first line of medical screening of casualties and also as dressing stations for minor injuries. However, patients with impending or severe shock may be detained in "A" Stations for treatment when major surgery is not immediately necessary to preserve life.

2. "B" Stations

"B" Treatment Stations are located in buildings with facilities which would permit setting up emergency surgical units capable of almost any operative procedure immediately necessary to save life. They will also function as a second line of medical screening, sending on to out-of-county "C" Stations such casualties as require major surgical operations and who can stand transportation.

3. "C" Stations

The only "C" Stations set up for immediate operation in Marion County are at Sunnyside Sanatorium and at Fort Benjamin Harrison, Billings Hospital. These are the only institutions with x-ray and surgical facilities in the county which are far enough removed from probable "ground zero" to give promise of survival as functioning units. They are also sufficiently remote that they would not be surrounded by a hopeless tangle of transportation difficulties. The adjunct "C" Treatment Team assigned to each is designed to permit the care of all kinds of casualties. However, the team assigned to Sunnyside is slanted particularly toward the care of chest injuries, which should therefore have top priority for dispatch thereto.

In the three surrounding rings of mutual-aid support counties are hospitals which are counted upon to implement with x-ray and surgical facilities adjunct "C" Treatment Stations. Each such hospital has been requested to find a nearby building suitable for a "field hospital" ward for the pre- and postoperative care of casualties.

It is planned by the Executive Committee to dispatch professional assistance to these mutual-aid hospitals. A small pool of unassigned specialists has been reserved for that purpose. Additional personnel could be withdrawn from stations within Marion County as the first-aid and screening work were accomplished.

Only transportable casualties requiring major or definitive treatment which could not be provided in Marion County should be sent to these more distant "C" Stations. It is expected that some of the Indianapolis hospitals might be able to function effectively within a few days. Their adjunct "B" Treatment Teams would then automatically become "C" Treatment Teams.

4. Hospital Stations—Marion County

Any expectation that the existing hospitals of Indianapolis might by heroic efforts accomplish a large part of the emergency treatment must be rejected on logistical grounds: (a) Our hospitals, excepting Sunnyside and Billings General, are all located where they would likely be damaged if not destroyed. (b) Even if they were undamaged, they would almost certainly be deprived of power and water pressure for hours. (c) They are already filled to capacity and the evacuation of nonambulatory patients in order to make room for disaster casualties would only be trading one person's safety for another's, and impose a profitless burden on TRANSPORTATION. (d) No hospital can be accorded the medical staff necessary to stage a large-scale emergency service because it is necessary to provide medical service all around the disaster area along pathways of unpreventable refugee evacuation. (e) The transportation problem makes the concentration of large numbers of casualties within the city impracticable. (f) Large concentrations of casualties would add terrifically to the feeding problem, secondarily complicate the transportation problem, and favor outbreak of epidemic disease.

Should they survive, even though damaged, the hospitals could best serve by sharing their inventory of supplies with the dispersed Treatment Stations. They might also be able to implement adjunct "B" Treatment Stations with superior facilities. Therefore, to each has been assigned a "B" Treatment Team to work in the nurses home or other suitable nearby building, screening the casualties to be run through the hospital's x-ray department, operated upon in the hospital's operating room, and then to be returned to the nearby building which will function as a "field hospital" ward.

LABORATORIES

Equipment and personnel is in process of being provided for four emergency laboratories, one in an outer zone of each Quadrant:

SECTOR I in Quadrant 1—Headquarters Laboratory—Butler Field House
Horace M. Banks, M.D., Division Director

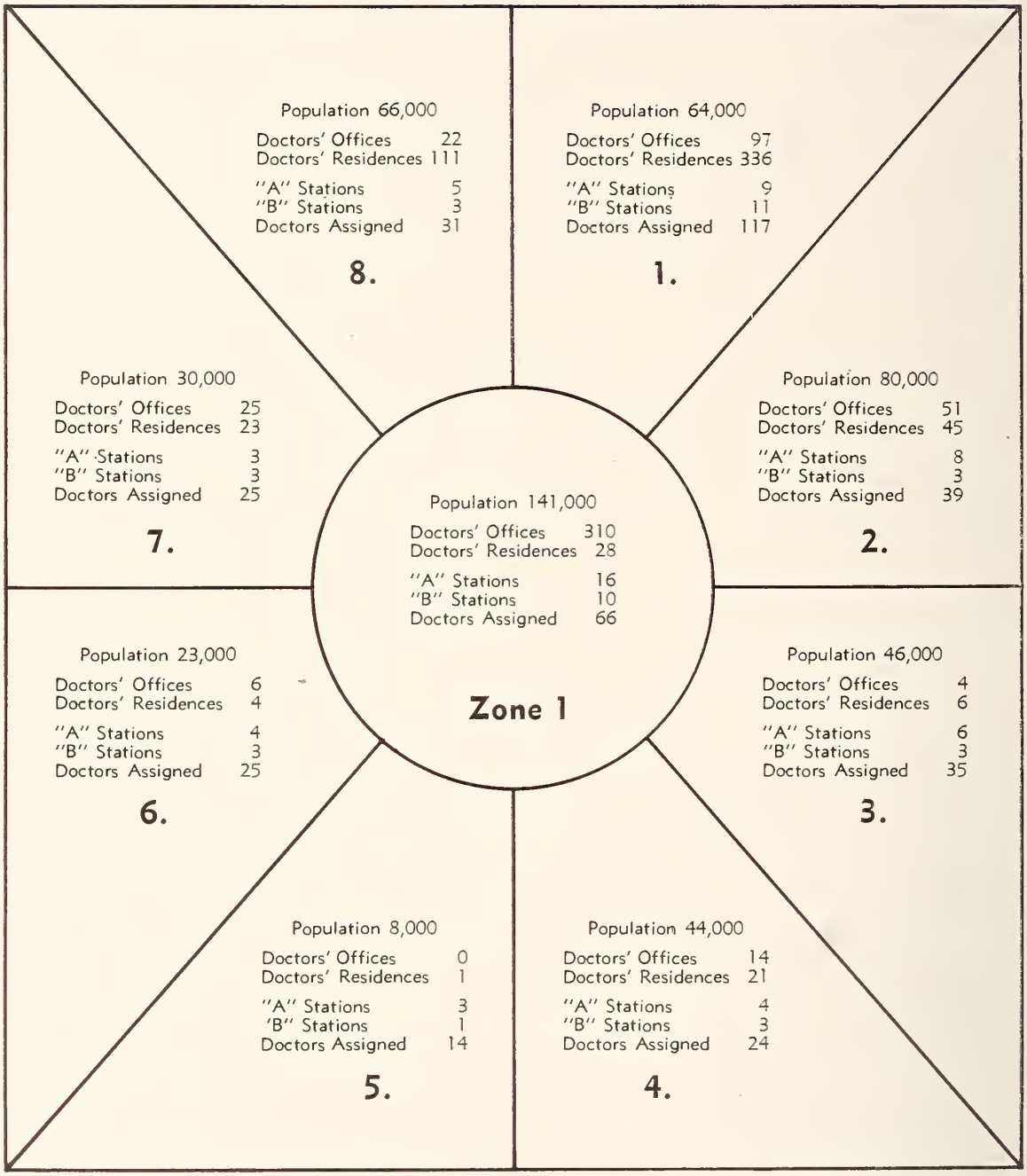
SECTOR II in Quadrant 2—Warren Central High School
Lester H. Hoyt, M.D., Division Deputy Director

SECTOR IV in Quadrant 3—Southport (Perry Twp.) High School
Harold C. Thornton, M.D.

SECTOR VII in Quadrant 4—Indiana Girls' School
Joseph L. Haymond, M.D.

LOGISTICAL PROBLEM: ASSIGNMENT OF DOCTORS

(Adjunct Hospital Teams Not Included)



Population of Marion County (official census)	529,863
Population of Indianapolis as estimated above	502,000
Population of all sectors outside of city limits	27,863

One or more of the already existing laboratories, some quite centrally situated, might escape destruction. Such a circumstance would require revision of assignment of pathologists at the time. This possibility of survival of existing laboratories has dictated that to each be assigned one unit of personnel to supplement its usual staff. One supplemental unit has also been assigned to each of the existing laboratories situated at a probably safe distance from the probable ground zero but in a location too inconvenient to meet the requirements of an emergency laboratory. These existing laboratories are as follows:

SECTOR VIII—Quadrant 1—
St. Vincent's Hospital
Methodist Hospital

SECTOR II—Quadrant 2—
Norways Sanatorium
Sunnyside Sanatorium
Billings General Hospital
Indianapolis Public Health Center

SECTOR IV—Quadrant 3—
St. Francis Hospital

SECTOR V—Quadrant 3—
Eli Lilly Co., Kentucky Ave. Hospital
Red Cross Blood Center

SECTOR VII—Quadrant 4—
I.U. Medical Center Hospitals
Indianapolis General Hospital
Central State Hospital
Cold Springs Road Veterans' Hospital

A unit of laboratory personnel will consist of the following:

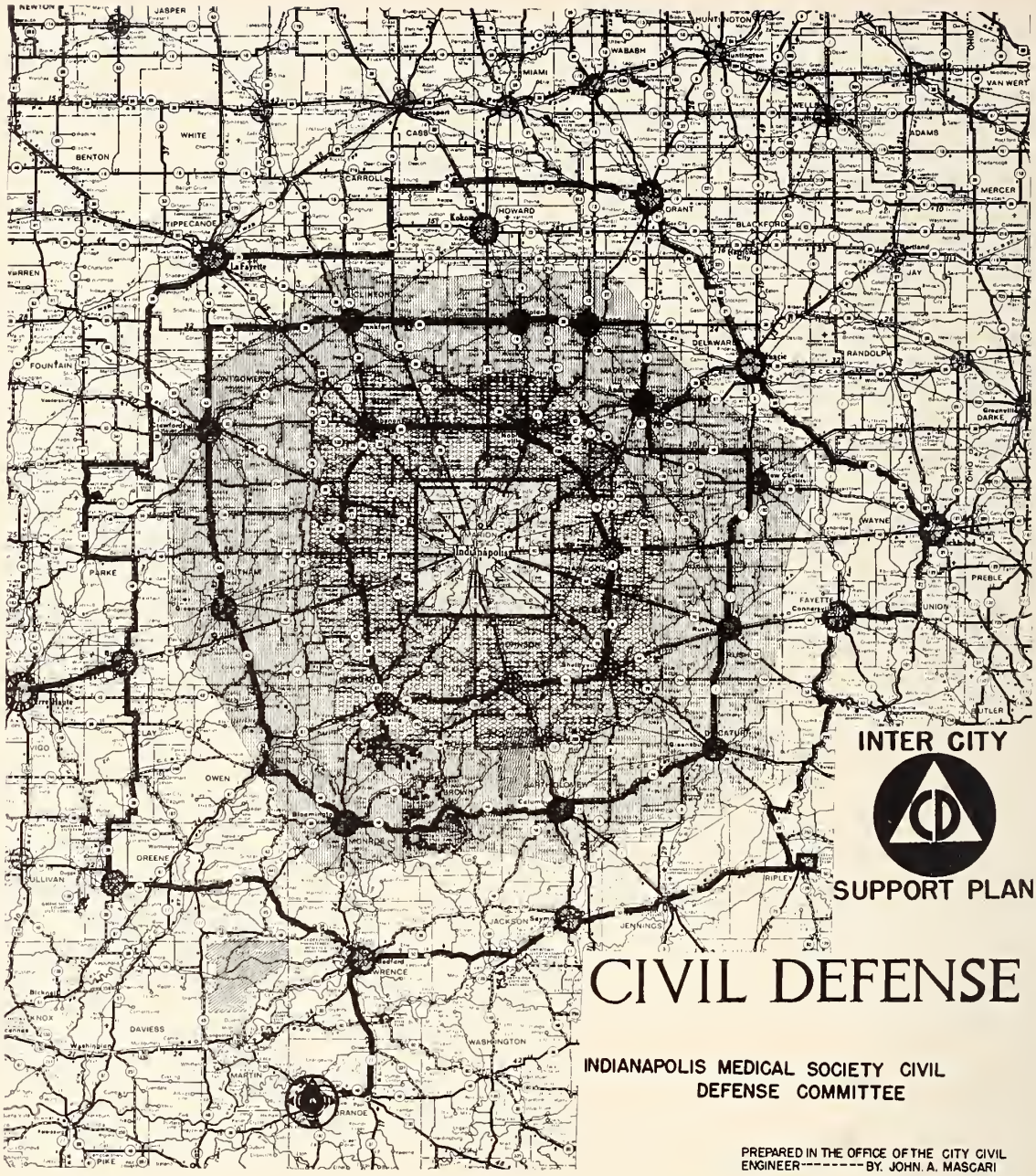
Pathologist: one
Registered technicians: six
Assistant technicians: six
Record clerks: four
Maids: four
Corpsmen: four

All registered and nonregistered laboratory technicians as well as all other trained laboratory personnel not specifically assigned to a laboratory station, or who find it untenable, are instructed to report to the Laboratory Headquarters (Butler Field House). Pathologists who are "smoked out" of their usual places of employment are instructed to do likewise. Mobile teams will then be improvised from this pool and dispatched where needed.

Civil Defense is everybody's business. Local and national medical groups are setting up and speedily putting into operation plans for the protection of the public and the prevention of panic. The health services, to be most effective, must be fully coordinated with other Civil Defense activities. Without adequate firefighting or rescue services, for example, many lives that could be saved would be lost because the first-aid workers could not reach the injured. This illustration points up the interdependence and cooperation necessary between all phases of the Civil Defense program.

You, the docors, have a most important part to play in the Civil Defense program. By your example and special knowledge of knowing what to do in an emergency, you give a feeling of security to the children, the family and the community.

FREDERICK CRETORS,
State Director
Civil Defense



CIVIL DEFENSE

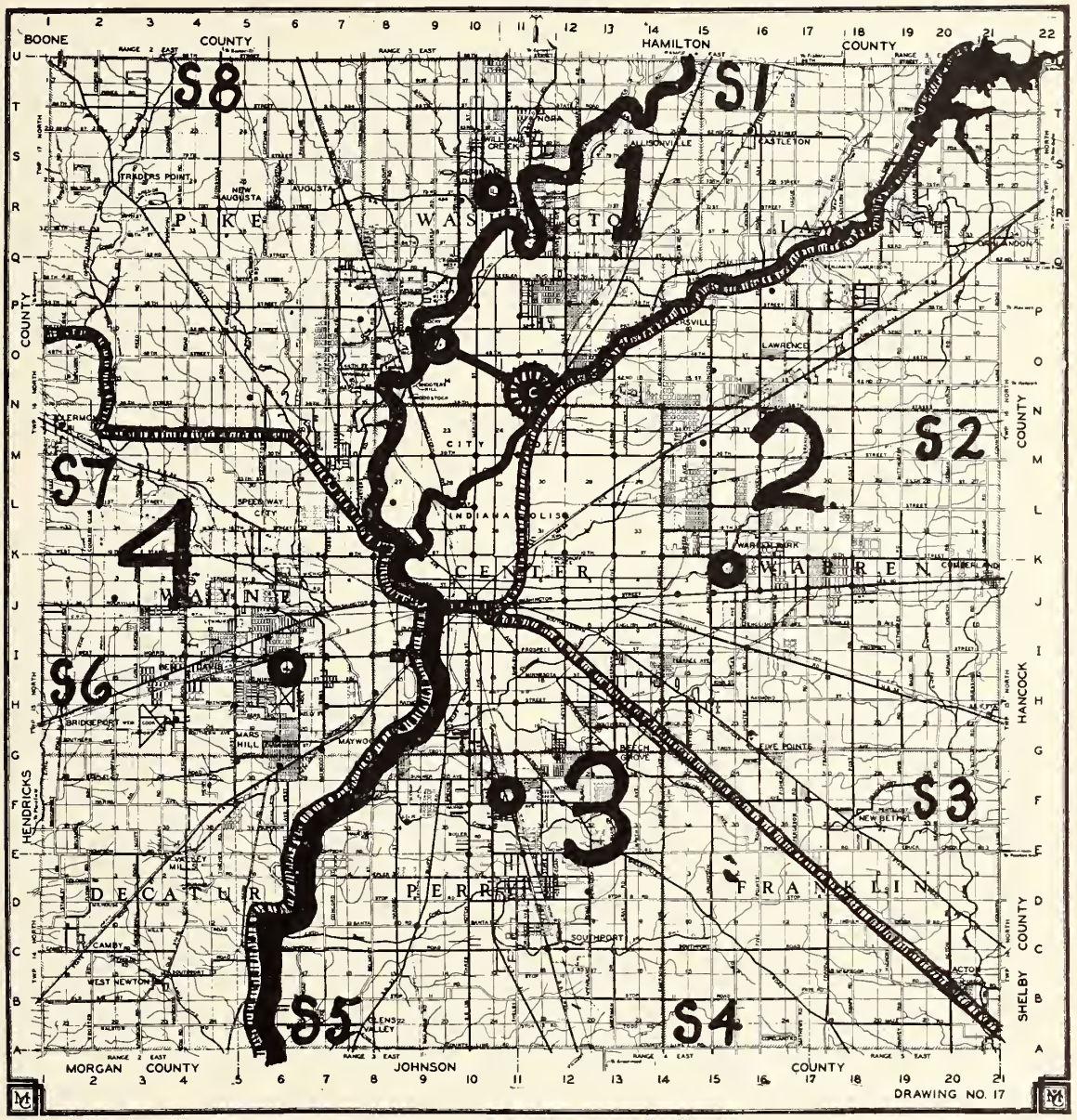
INDIANAPOLIS MEDICAL SOCIETY CIVIL DEFENSE COMMITTEE

PREPARED IN THE OFFICE OF THE CITY CIVIL ENGINEER--------BY. JOHN. A. MASCARI

This map of a portion of Indiana illustrates how a TARGET REGION may be organized around a TARGET AREA. The entire shaded portion represents the casualty and refugee absorption zones. The central light square is Marion County which would quickly become saturated with refugees from devastated Indianapolis. The next zone corresponds roughly with the seven immediately adjacent counties containing the first ring of SUPPORTING HOSPITAL TOWNS, six in number. The second ring consists of eleven SUPPORTING HOSPITAL TOWNS in portions of twelve counties. It is thought that casualty and refugee absorption might be practically completed by this zone. However, any overloading which might prevail therein could be relieved by the outer zone of counties containing the third ring of supporting hospital towns, all of which must recognize the possibility of overlapping claims of other target areas.

It is thought that possible claims for medical support from other target areas on the first and second rings of hospital supporting towns should be negotiated by the Marion County Civil Defense Organization. Such claims upon the third ring of supporting hospital towns would probably be negotiated by the Medical Division of the State Civil Defense Organization, which would have to assume responsibility for judicious allocation of assistance. Thus for each target region.

Use of the word "refugee" is not intended to imply approval of unregulated evacuation from target areas. The public should be fully apprised of the plan to establish firm road blocks immediately after a disaster in order to build up inhibition against the panicky impulse to flee—an impulse which might, if uninhibited, greatly interfere with orderly casualty relief and contribute to increase of mortality rate.



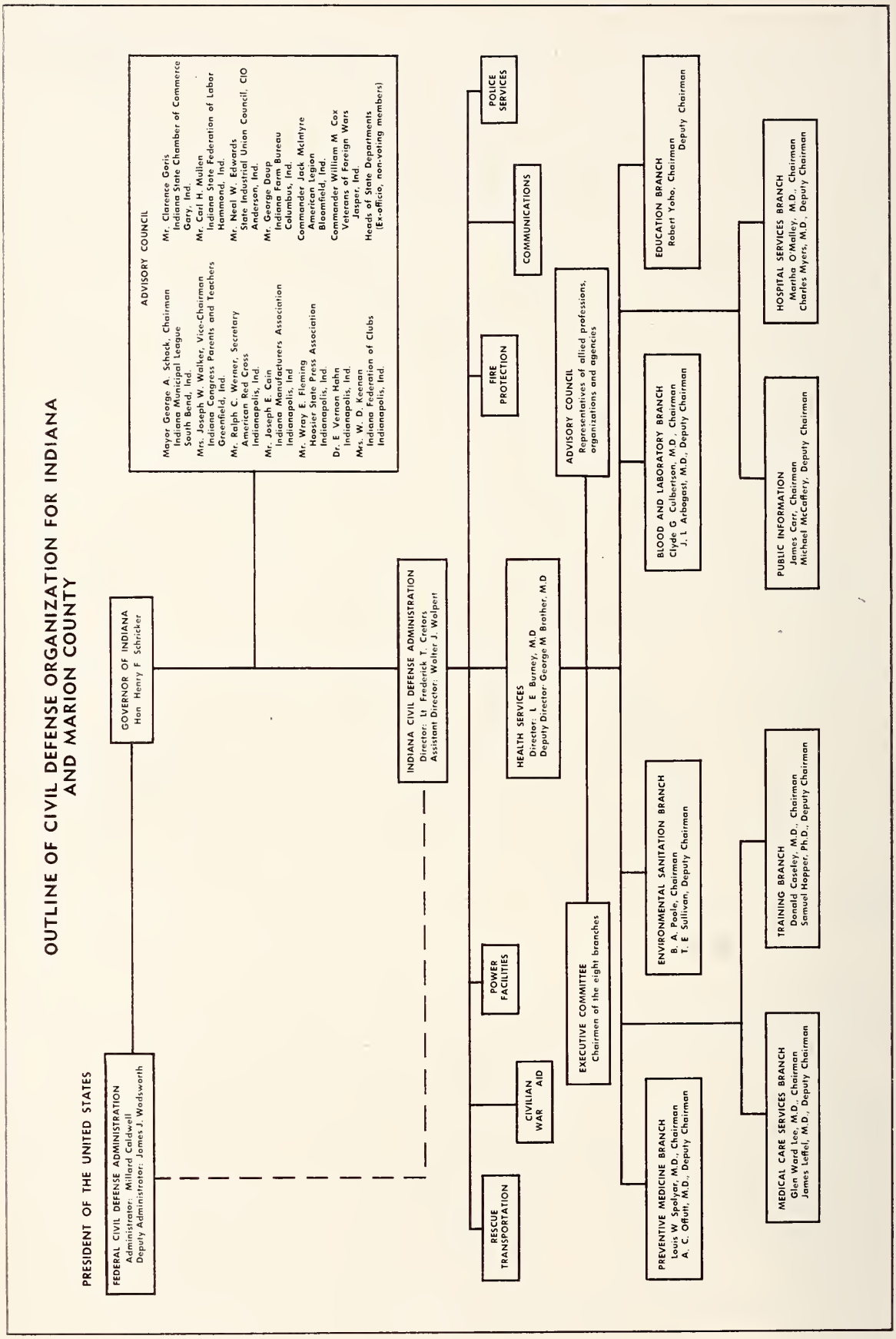
Provisional sketch of a map under preparation by Civil Defense Director, Charles R. Broderick, and Director of Communications Division, Colonel Foster B. Stanley.

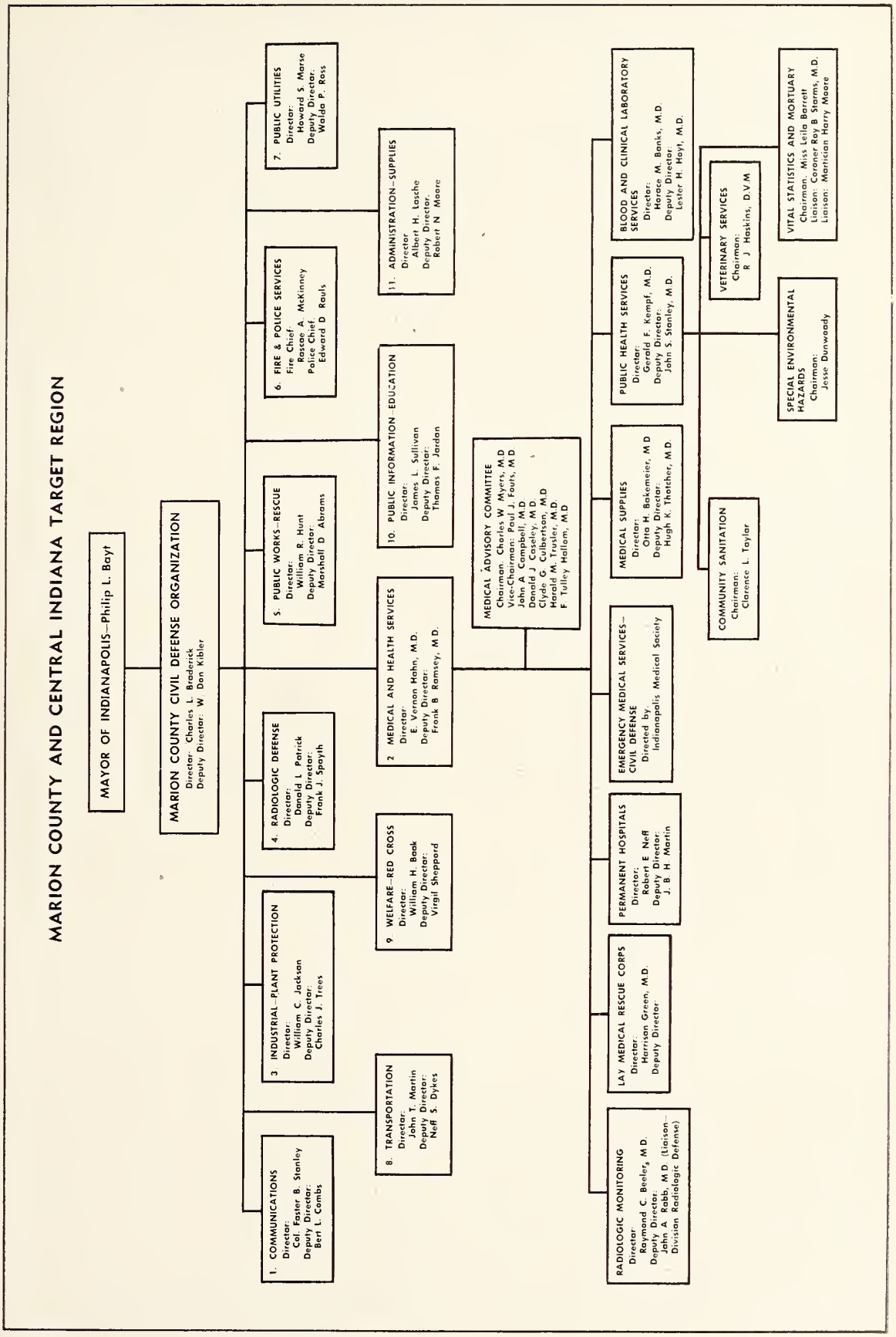
Districting of Marion County into four Quadrants was dictated by already existing telephone trunk lines. Note that Quadrant 1 roughly coincides with the Medical Division's Sectors VIII and I; that Quadrant 2 coincides with Sectors II and III; Quadrant 3, with Sectors IV and V; and Quadrant 4 with Sectors VI and VII.

The Marion County Civil Defense Organization is committed to the principle of DECENTRALIZATION. Each Quadrant will be staffed in such wise that it may function autonomously in event of disruption of centralized control.

The large cartwheel in Quadrant 1 is the primary control center at the Indiana State Fair Grounds. The other circles denote the secondary quadrant centers so far designated. Certain other features of the map are unlabeled because the information is "classified."

Each officer of the Medical Division will be provided with an unreduced edition of this map when it is completed, for the furtherance of smoothly operating liaison. In each Quadrant a Sector Officer (of the medical organization) will sit with the Quadrant control group. Most of the Quadrant control stations correspond with stations already designated as Sector Headquarters or Alternate Headquarters.


OUTLINE OF CIVIL DEFENSE ORGANIZATION FOR INDIANA AND MARION COUNTY
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Deputy Administrator: James J. Wadsworth
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Greenfield, Ind.
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Hoosier State Press Association
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Indiana Federation of Clubs
Indianapolis, Ind.
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Indiana State Chamber of Commerce
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Indiana State Federation of Labor
Hammond, Ind.
Mr. Neal W. Edwards
State Industrial Union Council, CIO
Anderson, Ind.
Mr. George Doup
Indiana Farm Bureau
Columbus, Ind.
Commander Jack McIntyre
American Legion
Bloomfield, Ind.
Commander William M. Cox
Veterans of Foreign Wars
Jasper, Ind.
Heads of State Departments
(Ex-officio, non-voting members)
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Assistant Director: Walter J. Wolpert
HEALTH SERVICES
Director, L E Burney, M.D
Deputy Director George M Brother, M.D
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POLICE SERVICES
COMMUNICATIONS
ADVISORY COUNCIL
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CIVILIAN WAR AID
POWER FACILITIES
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Deputy Director: W. Don Kibler
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Deputy Director:
Bert L. Combs
3 INDUSTRIAL—PLANT PROTECTION
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William C. Jacksen
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Deputy Director:
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11. ADMINISTRATION—SUPPLIES
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Robert N. Moore
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Vice-Chairman: Paul J. Fouts, M.D
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Chairman. Miss Leila Barrett
Liaison: Coroner Roy B Starms, M.D.
Liaison: Mortician Harry Moore

WHEN THE ATOM BOMB STRIKES INDIANAPOLIS

Operational Plan for Medical and Associated Personnel

EXECUTIVE COMMITTEE

1. Although the declaration of Martial Law might technically relieve the Civil Defense Organization of responsibility and authority, it would probably have little influence upon the course of events. Adequate military personnel to take over actual operations would probably not then be available. It is probable that military authority would have no other recourse than to delegate responsibility for medical Civil Defense operations back to the agency which prepared the plans.

2. The Executive Committee of the Indianapolis Medical Society Civil Defense Committee would function as a General Staff in directing *medical* activities. It would perform the following functions:

(a) Fill vacancies in its complement of officers and members.

(b) Direct Sector Officers and supervise field operations.

(c) Shift assignments of personnel to meet circumstances.

(d) Assign new recruits: staffs of defunct hospitals, medical and dental students, personnel from defunct industrial plants, etc.

(e) Through State Medical Civil Defense Director, request help from and dispatch help to mutual aid cities. If necessary, work directly.

(f) Through County Civil Defense Director, maintain liaison with other Divisions of County Civil Defense Organization. If necessary, work directly.

(g) Through channels, if possible, requisition supplies from whatever sources are available. Distribute same to Treatment Stations.

(h) Act as clearing house in medical matters, and as information bureau, observing channels in so far as possible.

(i) Keep the best casualty records possible.

(j) Exercise the duties of Coroner when necessary. (All members of Executive Committee and Sector Officers are already Deputy Coroners.) Maintain liaison with Coroner, other Deputy Coroners, and morticians.

3. All medical and associated personnel organized by the Indianapolis Medical Society Civil Defense Committee should bear in mind this chain of command for affairs within Marion County: Mayor→Director Civil Defense→Director Medical Division→Indianapolis Medical Society President→Senior Co-Chairman Civil Defense Committee→Junior Co-Chairman Civil Defense Committee→Senior Deputy Co-Chairmen in order of seniority →Vice-Chairmen in alphabetical order.

With respect to medical affairs extending beyond Marion County, the channel of authority is as follows: Deputy Chairman Medical Services Branch, James M. Leffel, M.D.←Chairman Medical Services Branch, Glen Ward Lee, M.D.←Director Health and Medical Services Division, Leroy E. Burney, M.D.←Director Indiana Department Civil Defense, Frederick T. Cretors←Governor.

MOBILIZATION

1. On highest authority, an attack without warning is possible.

2. It is probable that a "red" alert might allow five or ten minutes for taking shelter.

3. The earliest possible alert ("yellow") announcing practically certain attack upon Indianapolis would allow less than an hour for preparations. Such an alert would be held highly confidential among key personnel in order to prevent public pandemonium which would cause more casualties than if warning preceded the burst by only a few minutes.

4. It is probable that the Executive Division would quickly learn of a "yellow alert" and undertake such steps as might be permissible to direct Sector Chiefs to their respective Sector Headquarters. General mobilization would probably be impossible prior to the bomb burst.

5. If, on the contrary, a "yellow" alert should permit more complete mobilization, personnel should take cognizance of restrictions which will be placed at the central offices on outgoing phone calls, except for certain privileged phones.

The office and residence phone of each member of the Executive Division and of each Sector Officer will be privileged, as also one or two trunks in each hospital. In or near each Treatment Station will be a privileged phone or phones. The location at various points throughout the city of other such phones is "classified" information.

Sector Chiefs and Deputy Chiefs who have been alerted are instructed to meet immediately to divide the task of phoning Captains and Deputy Captains of Treatment Teams. By working together they may avoid duplicating calls. It is not known presently whether outgoing phone service can be accorded to the Captains.

Key personnel among the Associated Services will be notified as promptly as anyone else, and will proceed in the manner described.

6. When aware that a bomb burst is imminent, all personnel should endeavor to survive, following the advice given to the general public. A last minute attempt to reach a post of duty might prove fatal.

7. Remain under shelter until "all clear" is sounded, but not longer than five minutes. Then, try to reach your assigned post of duty.

8. You are asked not to tarry to administer first aid or effect rescues in your immediate area no matter how challenging the situation might be.

9. You will not be able to determine from your immediate observation the boundaries of the devastated area nor to predict the places where casualties will need your services most. Therefore, you should act in accordance with the predisaster plan in so far as possible.

10. It is recommended by the Civil Defense Committee that doctors with a second car, usually kept at home in an outlying residential district, keep same full of gasoline at all times and provide it with an emergency medical kit, a supply of splints, and packaged material for bandages. The "mortality rate" of cars parked in lots downtown would probably greatly exceed that of their owners.

PROCEDURE AFTER THE BLAST

1. An aerial atomic explosion will produce an area of complete destruction practically one mile in diameter. Casualties within this area will mostly be fatal ones and those still living will be destined to die within a relatively short time. Rescue and treatment efforts should therefore not be wasted in this area until the larger number of living casualties of better expectancy in a surrounding belt two miles wide are cared for. This instruction is protective also of rescue workers with respect to radiation hazard. Radiologic monitors will determine the safety limits as soon as possible.

2. The Treatment Stations of any central area of complete devastation would naturally be untenable, as also many of those in the surrounding two-mile-wide Major Casualty Belt. The personnel assigned to those stations are instructed to redeploy themselves into improvised teams of two or three members and to set up emergency stations along the outer edge of the Major Casualty Belt. These teams should distribute themselves as equitably as possible among eight segments of the Belt corresponding with the eight Sectors of the master plan. In general, personnel with a predisaster assignment in a given Sector should gravitate to the corresponding segment of the Major Casualty Belt. Prevalence of this concept may promote equitable distribution.

3. These extemporized Treatment Teams made up of personnel displaced from their predisaster assignments come close to constituting "roving teams." However, it is not thought expedient for doctors and their assigned associated personnel to move from casualty to casualty, but rather to operate in fixed, extemporized stations even though these be of only temporary occupancy. Rescue personnel working in any neighborhood will quickly learn where a small group of doctors, nurses, corpsmen, and Red Cross trainees may be found, and will bring or direct the casualties to them.

4. Casualties who are only dazed or who seem to have only minor injuries and who can walk are to be directed to the nearest neighborhood First Aid Station. (These are not staffed by doctors and are therefore not included in the Civil Defense Committee's schedule of stations.)

5. Casualties requiring medical attention should be directed to the nearest "A" Treatment Station or taken to a "B" Treatment Station.

6. Stretcherbearers, ambulances, station wagons, trucks, and automobiles will be standing at the perimeter of the Major Casualty Belt or cruising in its outskirts, working in as closely as possible. Police will establish a limiting line of safe penetration.

7. All personnel working in the Major Casualty Belt and later in the central area must keep track of time spent in this region of possibly heavy contamination (especially in event of a near ground-level burst). Radiologic monitors will announce by megaphone the maximum safe exposure period. A worker exposed continuously for such elapsed time must retire to the nearest "A" Treatment Station outside the contaminated zone to exchange places with a worker who has not been exposed. Owing to rapid decay of nuclear contamination this relay system will probably not be necesary after the first twelve hours.

8. If a "fire storm" or fires threaten a rescue region, prescribed precautions against moving casualties with impending shock must be disregarded and all emphasis placed upon immediate evacuation of living casualties.

9. Casualties who are dead beyond a doubt should be marked with a conspicuous cross on forehead or other area of skin by the first examiner so as to be passed over quickly by subsequent medical rescue workers. It is planned that removal of the dead to designated Mortuary Stations will be carried on by mortician teams simultaneously with rescue of the living.

10. The first worker to examine a casualty must establish his identity, if possible, recording same in a notebook. (A casualty able to communicate identity might soon be in coma or dead and then completely unidentifiable.) The identity is then to be entered on the official tag to be attached to the casualty. Spaces on the tag for classification and destination data must be left blank for use of doctors. (First aid workers will mark forehead and tag with a T if a tourniquet is applied.)

11. At the first Improvised Medical Station or "A" Treatment Station or even "B" Treatment Station to which the casualty may be directed, conducted, or carried, classification and destination will be entered on the tag.

12. All doctors and associated personnel, and in fact all rescue workers, must wear a mask over nose and mouth, improvised if necesary. This is for (a) protection of themselves from possible inhalation of radioactive dust, and (b) protection of casualties with burns or large wounds from infection by respiratory droplet contamination.

FIRST AID, HANDLING AND CLASSIFICATION OF CASUALTIES

(Simplified Treatment Plan)

FOREWORD

THE treatment outlined has been written under the direction of the following subcommittee: Drs. Frank B. Ramsey, chairman, Kenneth G. Kohlstaedt, Harold M. Trusler, Philip L. Kurtz, D. Hamilton Row and J. Neill Garber.

Only the briefest reference has been made to theory. The object has been to call attention to the special features of treatment necessitated by disaster conditions. This outline is expected to serve as a guide to those responsible for the training of nonmedical personnel engaged in first aid activity.

GENERAL PRINCIPLES

1. Shock

Even though it is not immediately evident, shock must be expected in all casualties who have been subjected to severe physical force. Fractures are evidence that such force has been sustained. A person with twenty percent or more of the body surface burned is likely to develop shock. Burns of the nose and throat from inhalation of hot gases are also dangerous injuries.

A casualty with evidence of shock-producing injury may seem at first to be in good general condition and may say he "feels all right." Nevertheless, he must be watched closely for signs of shock and handled so as to minimize likelihood of its development. In so far as prevailing conditions permit, the following precautions are to be observed:

1. Control hemorrhage by ligation of large bleeding vessels, by tourniquet, or by pressure dressing. Do not cover up bleeding—Stop it!
2. Splint all fractures prior to transporting patient.
3. Avoid unnecessary transportation of the injured.
4. Insulate patient from ground and air by blankets, papers, et cetera. In other words, keep him warm. Also enjoin rest.
5. If possible, administer plasma and whole blood intravenously until pulse and blood pressure show improvement. The ratio of two units of plasma to one unit of blood is recommended.
6. If oxygen is available, give it in severe cases.
7. Do not give morphine until shock is relieved, and even then in small doses and sparingly.

2. Pain

Adequate supplies of morphine for an atom bomb disaster are not in sight. At best, it will be in short supply. Stocks will have to be stretched by use of small doses and by substituting other analgesics. The following points should be observed:

1. Morphine (Demarol, methadon, et cetera) should not be given routinely to all injured. Those who do not complain of pain may be in shock, in which case narcotics are dangerous. Some of those who complain of pain may respond to encouragement and a placebo.
2. Codeine, phenacetin and aspirin, may suffice.
3. Combining a sedative drug (Phenobarbital, etc.) with an analgesic may give better results than either alone.
4. Narcotics should not be used in manic or hysterical states. Phenobarbital, paraldehyde, pentothal, are preferable.
5. Narcotic drugs must not be given to those who are ambulatory.
6. Smaller doses of narcotics than commonly used are often effective and less dangerous than large ones.
7. Head injury cases must not be given narcotics.
8. Subcutaneous or intramuscular injection of any drug may be ineffective when the circulation is too poor to pick up the agent and carry it to the brain. Intravenous injection should then be employed.
9. Simple surgical attentions such as posturing and bandaging may relieve a great deal of distress and even pain.

(See TREATMENT)

3. Panic and Hysteria

Self-assured, *firm* handling by a doctor will suffice to control many a case of the "run-arounds."

Drastic doses of hypnotics and sedatives should not be given at first. Such drugs should be used practically as placebos until need for truly effective doses is manifest.

Maniacal patients with severe injuries requiring treatment in a Treatment Station must be "snowed under."

Maniacal and hysterical patients who are not injured must be ejected from Treatment Stations and committed to the custody of the police, who will conduct them to a Psychiatric Station (one in each Sector).

4. Obstetrical Cases

Women threatening abortion or full-term delivery are to be sent, conducted, or transported to nearest "A" Treatment Station. Direct such away from "B" Treatment Stations and by no means send to a "C" Treatment Station, unless requiring operation.

SORTING OF CASUALTIES AT SCENE OF INJURY OR IN MAJOR CASUALTY BELT

Sorting in the close-up zone will turn upon the need of casualties for first aid treatment prior to transportation. In deciding whether to treat prior

to evacuation or to evacuate immediately, medical personnel will have to be influenced by information provided by nonmedical fire and radiologic monitors. Immediate evacuation may be more important than observance of medical principles.

First aid treatment in the Major Casualty Belt will necessarily be restricted to a very low minimum because (a) few buildings will be left standing and in condition for safe use as improvised Treatment Stations, (b) the terrain may be contaminated with nuclear dust, (c) danger from fire will be imminent, (d) supplies will be minimal, (e) the large number of workers required for extensive treatment would create intolerable congestion. Early dispersion of casualties is therefore essential.

Shelter will be of great importance in case of rain accompanying or quickly following an overhead atomic blast.

Casualties should be appraised according to the following schema:

1. Casualties requiring treatment before transportation:
   - (a) Temporarily suspended respirations. Obstructed airway.
   - (b) Active dangerous hemorrhage.
   - (c) Serious or impending shock.
   - (d) Sucking wounds of chest.
   - (e) Eviscerating wounds of abdomen.
   - (f) Fractures (other than strictly minor ones).
2. Casualties ready for evacuation:
   - (a) Those for whom nothing need be or can be done on the spot:
     - a′—Ambulatory casualties with minor injuries.
     - b′—So severely injured that time works against them.
   - (b) Cases from group (1) who have been treated and are ready for transportation.

Treatment in the Major Casualty Belt will necessarily be limited to (a) artificial respiration and establishment of airway, (b) control of severe hemorrhage, (c) short lapse of time for improvement from shock, (d) approximately airtight covering of sucking wounds of chest, (e) protective dressing over eventrated viscera, and (f) simplest immobilizing splinting of fractures.

CASUALTY CLASSIFICATION

CLASS 1—Top Priority for Transportation

Class	Description	Destination
1-M	Requiring immediate nonoperative treatment:	
	(a) Severe or impending shock without indication for surgery.	"A" Station
	(b) Burns of over 20 percent of body surface.	" "
	(c) Unconsciousness of undiagnosed cause.	"A" Station
	(d) Simple skull fracture and concussion of brain.	" "
	(e) Unmanageable psychiatric conditions.	Psychiatric Station
	(f) Labor cases—impending delivery.	"A" Station
1-S	Requiring immediate operation:	
	(a) Avulsion of limb.	"B" Station
	(b) Exsanguination with wound which may bleed again.	" "
	(c) Eviscerating abdominal wound.	" "
	(d) Sucking wound of chest.	Sunnyside
	(e) Chest crush.	Sunnyside
	(f) Large laceration or crush of soft parts.	"B" Station
	(g) Internal hemorrhage.	" "
	(h) Compound fractures requiring immediate operation.	" "
	(i) Cases with tourniquet (Skin-marked or tagged T).	" "

CLASS 2—May await delayed transportation in any casualty station.

2-M	Needing postponable medical or only minor surgical treatment.	
	(a) Minor abrasion, contusion, laceration.	"A" Station
	(b) Less than 20 percent burns.	" "
	(c) Known radiation exposure.	" "
	(d) Minor brain concussion.	" "
	(e) Near-to-term pregnancy.	" "
2-S	A. Needing postponable surgical treatment, major.	
	B. Needing postponable surgical treatment, minor.	
		"C" Station
	(a) Simple fractures, severe.	via "B" Station
	(b) Compound fractures without urgency.	" "
	(c) Penetrating injuries of joints.	" "
	(d) Scalp and face wounds.	" "
	(e) Dental injuries—fractured jaw.	" "
	(f) Eye injuries.	" "
	(g) Peripheral nerve injuries.	" "
	(h) Severe concussion of brain.	" "

(It is to be noted that casualties will not be dispatched directly to "C" Stations except to Sunnyside. If they can stand transportation to points outside Marion County, they can be assumed able to withstand screening at a "B" Station.)

(The shipment of casualties to points outside Marion County by rail from "A" and "B" Stations situated near railroads is to be con-

sidered only under extreme conditions and should be done only upon authorization by Executive Division of Civil Defense Committee or by Director of Civil Defense.)

CLASS 3—AMBULATORY CASUALTIES WITH STRICTLY MINOR INJURIES

(a) Emotional shock.	"A" Station
(b) General "shake-up."	" "
(c) Bruises, scratches, sprains.	" "
(d) Closed hematomata of minor importance.	" "
(e) Questionable exposure to radiation.	" "
(f) Small first degree burns.	" "

(Records should be kept of these casualties and they should be tagged. It is possible some may develop more serious symptoms.)

MEDICAL TREATMENT

Treatment in Aid Stations and Temporary Hospitals

1. General Principles

The basic principle for treating a large number of casualties, when time and supplies and personnel are limited, is to apply the least amount of therapy which will possibly aid the patient and probably save his life.

Meager supplies must be divided among as many of the injured as possible.

First aid measures and dressings should not be repeated except for urgent reasons.

Any type of treatment which can possibly be postponed to a later time should not be given until later.

To conserve time and to promote the treatment of the most urgent cases first, all casualties should be classified carefully. Casualty sorting should be a continuing process, so that patients who develop shock or who develop signs of an internal injury previously undiagnosed may be given immediate treatment.

Narcotic and analgesic drugs must be conserved. Do not use unless necessary and then only in the smallest dose. Many severly injured patients do not complain of pain; they should not receive pain-relieving drugs.

2. Wounds

Simple skin lacerations should be cleansed, and bleeding should be controlled, but the skin should not be sutured during the first 48 hours except in special instances, such as lacerations of the eyelids.

If nuclear contamination is known to prevail where the casualty was injured, repeated washing of the skin exposed to it is essential. Soap and water are presently recommended as effective.

Covering of raw tissues by materials which have possibly been contaminated by radioactive dust must be avoided.

3. Burns

The following outline is suggested as a guide to the management of burn casualties under catastrophic conditions:

I. RELIEF OF PAIN

1. Morphine or other analgesic drugs in appropriate doses.
2. Keep the burned area covered. Pain is greatly reduced by protective dressing.

II. DRESSING THE BURN

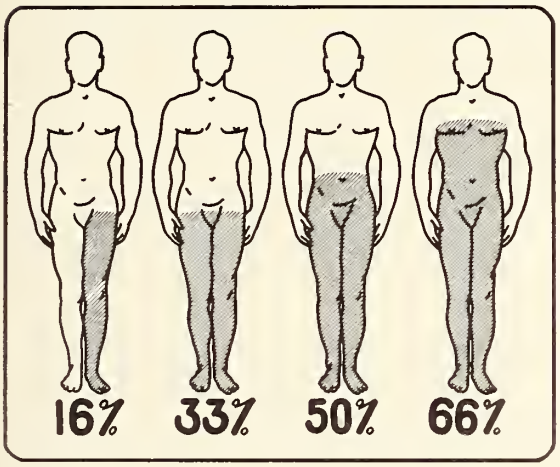
1. Remove gross dirt, charred clothing and debris from the injured skin but make no vigorous effort to clean the burned area.
2. Apply some type of protective dressing. If supplies are available the dressing should be sterile, nonadherent, absorptive and of sufficient bulk to be comfortable.
3. If there is enough bulky material in the dressing, pressure should be applied in the outer layer to produce a comfortable compression dressing.
4. If surgical dressings are not available use clean sheets or other fabric applied to the burned areas and fastened in place so as to give comfort and protection.
5. If dressing materials are scarce or unavailable, wrapping paper (preferably waxed) or clean newspapers may be utilized in the dressing.
6. Once an adequate dressing has been applied, nothing is gained by frequent changes. Unless there are gross complications, the dressing may be left in place for ten days. The dressing change should be done with sterile technique if possible. At the end of ten days it should be possible to estimate the depth and degree of the burns. Third degree burns should be skin grafted as soon thereafter as conditions permit.
7. The following procedure is recommended:
   (a) Inner layer of sterile rayon, silk or fine mesh gauze (ointment impregnated). Cleanest muslin available or waxed paper or even clean wrapping paper, if special fine-meshed gauze is not at hand.
   (b) Absorptive layer of dry gauze, cotton pads or clean mechanics waste.
   (c) Outer wrapping layer using roller bandage and elastic bandage or stockinette.
8. CAUTION: DO NOT WRAP TOO TIGHTLY! The initial layers especially should be laid on gently to avoid constriction. Excessive pressure in a poorly applied bandage may cause "tourniquet paralysis" or tissue necrosis. A bandage wrapped too tightly about the neck or chest may embarrass respiration and endanger life.

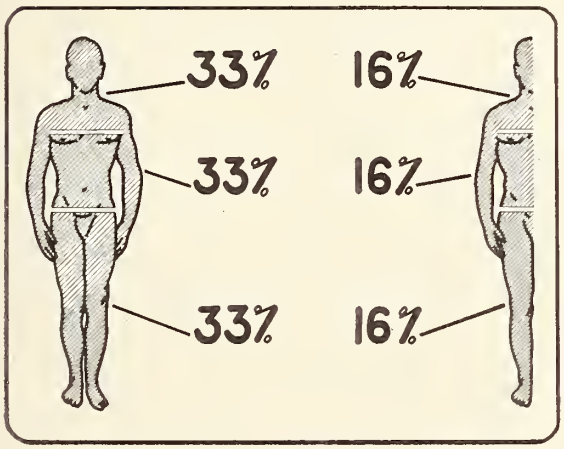
III. PERCENTAGE ESTIMATE OF BURN SURFACE

In view of the fact that the extent of burned surface gives the first clue as to the treament needs, patients should be surveyed and labeled as to the percent burned.

The following chart may be used:

Percentages indicate front and back combined.





Front only 16% **Front only 8%**
Back only 16% **Back only 8%**

Modified from Brown and Dziob.

4. BURN SHOCK

Fluid Administration

Burn shock is a very complex mechanism. This outline is not designed to portray a scientific exposition of the subject. The following statements are suggested as a practical guide to management of burn casualties under conditions of catastrophe.

Many patients with minor burns will turn pale and sick and may faint from pain and fright. This is not burn shock. Burn shock is secondary to loss of fluids from the circulation.

For this reason the treatment of extensive burns should include blood transfusions, plasma, and other intravenous fluids.

Question: How much fluid?

Answer: Under the conditions for which this is written no definite formula is practical. Due to the emphasis placed upon this phase of treatment in recent literature, the tendency is to give too much intravenous fluid. A good guide to fluid balance is adequate circulation of blood and continued output of urine.

1. Patients with less than 16 percent burn surface need no special treatment for shock due to loss of fluids (unless there is blast or other injury associated).
2. Patients with more than 16 percent burn surface are candidates for blood and/or plasma administration, but they may not need large amounts.
3. Patients with 50 percent or more of body surface *must* have transfusions of blood and/or plasma and balanced fluid administration or they will die.
4. Patients with total burns cannot be saved. They should be made comfortable.
5. Under conditions of catastrophe there may be so many severe burns that blood and plasma transfusions cannot meet the demand. The oral administration of ordinary water in large quantities will deplete the blood chlorides and cause "water intoxication" in the severely burned.
6. We recommend the oral administration of the so-called "burn cocktail" prepared as follows:

To each quart of water add one level teaspoonful of salt (sodium chloride) and 2/3 teaspoonful of baking soda (sodium bicarbonate). If conditions permit, the flavor of this drink may be improved by the addition of lemon juice or citric acid and sugar. Patients should be allowed to drink this fluid according to thirst. In the severe burns a record of fluid intake and output should be made as soon as possible.

5. PHARYNGEAL BURNS

In patients with burns of the face, nose and mouth, the question of pharyngeal burns and damage due to inhalation of hot gases is of great importance. These patients may need oxygen and drugs to combat pulmonary edema. Tracheotomy may be necessary. These patients are safer and more comfortable in semi-recumbent position, not lying flat.

6. FRACTURES

General Considerations

It must be repeatedly emphasized that immediate splinting of a fracture at the scene of injury before the patient is moved to a treatment station is essential to his welfare. The state of shock

may be avoided and, if present, may be shortened by careful application of splints.*

Fractures involving the spine, pelvis, thigh and leg are the most serious as regards the patient's general condition. These areas are relatively well protected by soft tissue or the bones are heavy. Hence, violent force is necessary to produce the fracture. The greater the violence to the person as a whole the more certain is shock to appear immediately or soon after the injury. Movement of such a patient even a short distance without splints allows painful motion of fractured bone ends and adds damage possibly beyond his limit to endure.

Fractures are simple, comminuted or compound. A bone broken into two fragments with the overlying skin intact is a simple fracture; a bone broken in three or more pieces is comminuted; and any fracture which has an opening to the outside through a cut or tear of the skin is a compound fracture.

The compound fracture has the additional hazard of infection from dirt and other foreign material entering the wound. These fractures are common in catastrophes. The splinting of such fractures is the same as for the closed fractures after the wound has been covered with sterile dressing.

First aid measures for a compound fracture of any bone include:

1) control of profuse bleeding by tourniquet or pressure dressing.

2) covering the wound with sterile dressing; and,

3) application of a splint.

No effort should be made to put back bone fragments which stick out through the skin, nor are they to be picked out and thrown away. The aim is to prevent further contamination of the wound by covering it with a sterile dressing, and to prevent further damage by putting the extremity to rest in a splint.

It must be assumed that conventional splints such as the Thomas leg splint and even stretchers will not be available in sufficient quantities if large numbers are injured. First aid workers will have to improvise by using doors to carry patients, long boards for splinting thigh fractures, pillows and blankets with short board reinforcements for injuries of the leg, and newspaper or magazine splints for fractures of the forearm and hand.

A door or a wide board, padded with a blanket, is probably the best means of transporting a person with a fractured spine or with multiple fractures of the extremities because of the support it alone provides.

Patients with fractures involving only the upper extremity can ordinarily walk to the nearest aid station. The stretcher or door and the carrying personnel are reserved for the more seriously injured.

Head

I. Signs

A. Patient may be unconscious or irrational.

B. Bleeding from the ears or nose.

II. Care

A. Cover wounds with sterile dressings.

B. Turn head to the side so that blood or vomitus can drain from the mouth.

Neck

I. Signs

A. Pain and stiffness in the neck.

B. Patient tries to hold the head still and resents any movement of the head because of pain.

II. Care

A. Maintain the head in the position of "looking straight ahead" by support on each side with padded stones or bricks.

B. Place the patient carefully onto the stretcher holding the head straight with the body. Do not let the chin flex onto the chest or the head fall toward either shoulder. One person should support the head while the patient is being moved.



Padded stone or brick on each side. Keep chin up—don't allow to fall forward onto chest.

Shoulder and Arm (above elbow)

I. Signs

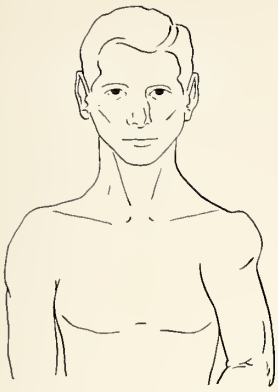
A. Swelling with pain and limitation of motion are present in shoulder fractures.

B. Fracture of the arm bone produces angulation of the arm and pain localized between shoulder and elbow.

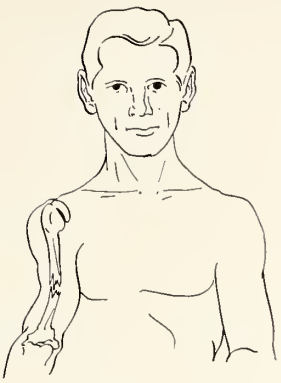
II. Care

A. *Do not use* the ring splint sometimes recommended for arm and shoulder fractures. When traction is made on the arm through this splint the ring is pressed too tightly into the arm pit so that it shuts off circulation to the hand.

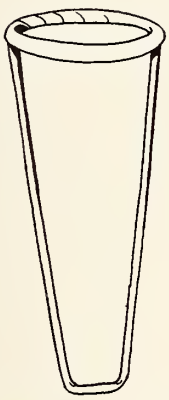
* Note previously stated exception that local conditions may preclude any first aid before evacuation.—Ed.



Dislocated shoulder. Note depression beneath tip of shoulder.



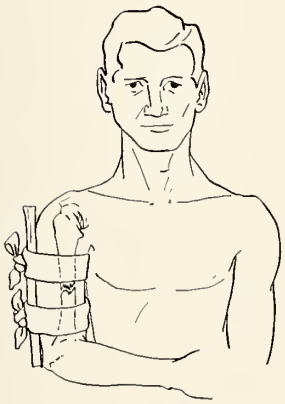
Fracture of arm bone (humerus). Note angulation of arm and painful abnormal motion.



Ring splint. DO NOT use for arm fractures!



Sling holding arm at side, forearm across chest and elbow flexed comfortably near a right angle.



Tie board along side arm for fracture of humerus. Place lower bandage above elbow crease and do not tie either one tightly. Apply sling over this.

Elbow-Forearm-Wrist-Hand

I. Signs

A. Pain, swelling and deformity are seen in these injuries. Fractures of the forearm may cause angulation between elbow and wrist.

B. Elbow fractures are especially serious because the displaced bone fragments and the swelling which appears quickly may obstruct circulation into the hand.

II. Care

A. Most patients with these injuries can walk to the aid station, but those having severe elbow injuries should be transported by stretcher so that the arm can be elevated to prevent excessive swelling.

B. The injured elbow is splinted in a sling which holds the joint comfortably near a right angle. Actually, splinting the elbow in the most comfortable position for the patient is the best guide. A dislocated elbow may be more comfortable splinted on a pillow tied about the arm with the joint almost straight.

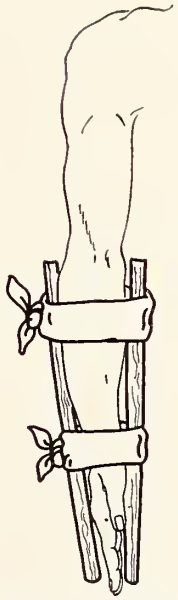
C. Forearm fractures are splinted by two narrow boards applied to the back and front of the forearm from elbow to fingers. If wood splints are not available wrap a magazine or newspaper about the forearm and tie it with two or three loops of cloth.

D. Splints for wrist and hand injuries are the same as those used for forearm fractures.

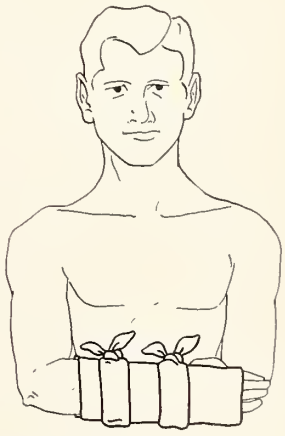
E. After splints have been applied support the arm in a sling at the side. Look at the color of the fingernail beds frequently. If these are blue or if there is intense pain in the arm, loosen the ties about the splint, have the patient lie

B. Apply a sling holding the arm at the side, the elbow at a right angle and the forearm across the chest. Place a short board splint alongside the arm from shoulder to elbow when the fracture is between these joints.

C. A dislocated shoulder may sometimes be more comfortable with the arm splinted straight at the side of the body. Let the patient find the comfortable position and then splint it there.

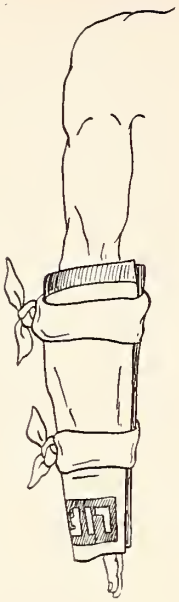


Padded board splints for injuries of forearm and hand.



Splint must not press into bend of elbow.

down and elevate the arm above the shoulder level. Be certain the splint does not press into the bend of the elbow. This can interfere with circulation and must be corrected.



Magazine or newspaper splint for forearm or hand injuries. Add sling over splint.

Spine

I. Signs

A. Severe pain in the back.

B. Weakness or paralysis of the legs along with back pain indicates a severe spine fracture or dislocation which has damaged the spinal cord.

II. Care

A. All back injuries must be handled with greatest care to avoid injury to the spinal cord.

B. Do not lift the patient face up by his arms and legs as this bends his back and may increase his injury.

C. Gently straighten the body and legs and roll the patient onto a padded door, face down. Turn the head to one side to facilitate breathing.

Pelvis

I. Signs

A. Fracture of the pelvis may be present when there is pain across the hips and lower abdomen. One should be suspicious of this injury if there has been a crushing force about the hip region.

II. Care

A. Transport the patient on a padded door or stretcher.

Hip-Thigh-Knee

I. Signs

A. Pain on movement of the leg.

B. The foot on the side of a fractured hip may roll farther outward than the foot on the uninjured side, and the leg is shorter.

C. Thigh fractures show an angular deformity —abnormal bend—between the hip and knees, with pain here on motion.

Hip fracture. Leg and foot may be rolled outward.

D. Swelling and pain about the knee are present when this joint is fractured.

II. Care

A. These fractures are best immobilized by traction on the foot through a Thomas leg splint if it is available.

B. Other methods.

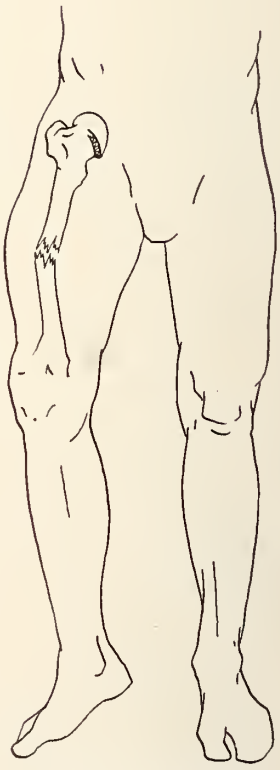
1. Gently straighten the leg while traction is maintained by pulling of the foot.

2. Lay a 4 or 5 inch board alongside the body and the injured leg, from armpit to the sole of the foot.

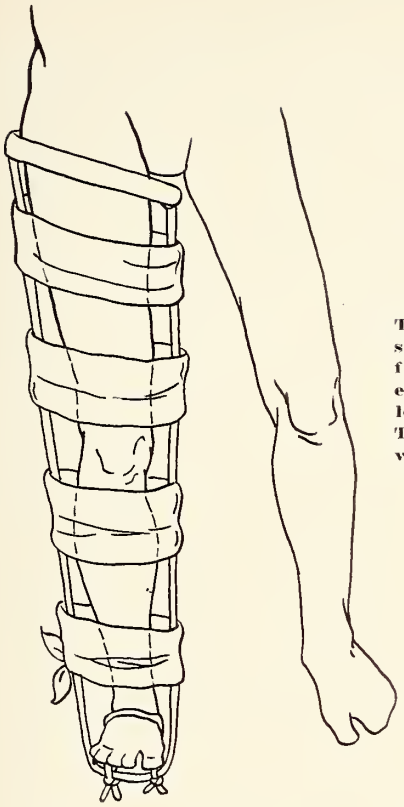
3. Place a shorter board along the inner side of the thigh and leg from crotch to foot.

4. Secure the longer board to the body with several ties about the chest, and tie several bandages around both boards with the leg between them.



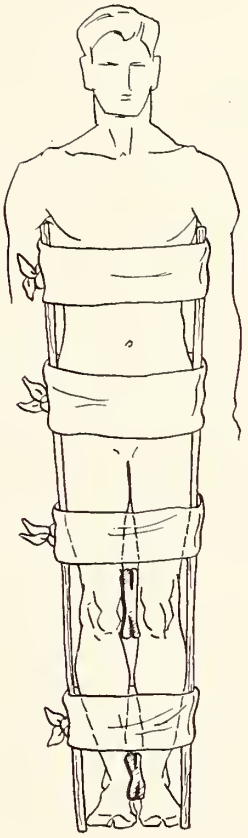


Angular deformity of thigh in fractured femur.



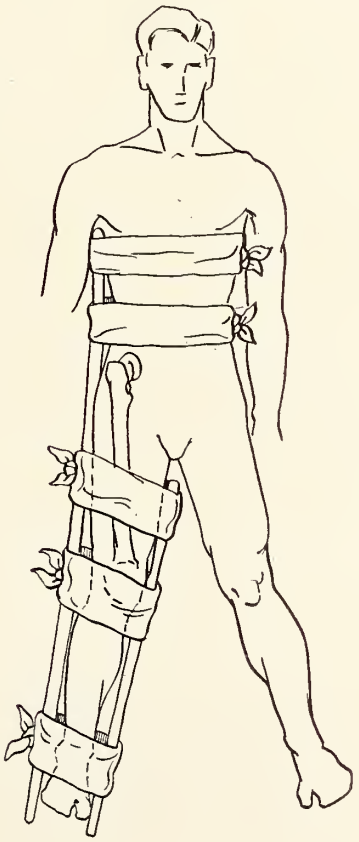
Thomas ring splint for thigh fracture. Towels supporting leg in splint. Traction downward on foot.

5. If both hips or thighs are fractured a long board is placed along each side of the body from the armpits to the sole of the feet. These are secured to the body by bandages and are tied together above and below the knees with both legs held between them. Put thin pads between the knees and ankles to prevent pressure on the bony prominences.



Both hips or thighs.

Small pads between knees and ankles.



Do not tie so tightly that breathing is hindered.

Padded 4 inch boards.

Leg-Foot

I. Signs

A. Pain, swelling and deformity.

B. Compound fractures are common as bone lies close beneath the skin.

II. Care

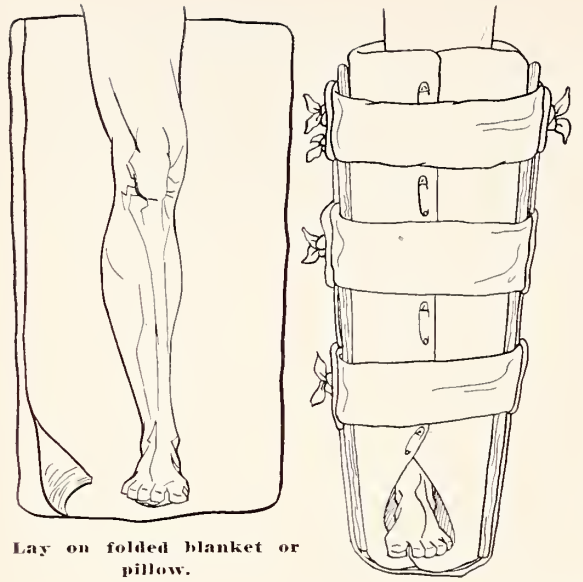
A. Place the leg on the pad of a pillow or folded blanket extending from mid-thigh level to a short distance beyond the foot.

B. Two thin boards, about three inches wide and as long as the pad, are laid outside the pad along each side of the leg, and a third board is placed along the back of the leg.

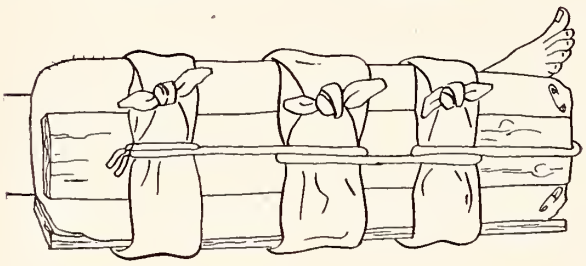
C. Gently straighten the leg while traction is made on the foot.

D. Close the pad over the front of the leg and beneath the sole of the foot with safety pins.

E. Tie the boards around the pad with cloth strips above and below the knee and around the ankle.



Lay on folded blanket or pillow.



F. Tie a long narrow bandage to the highest encircling strip above the knee, carry it down along the board on the outer side of the leg, across the sole of the foot and up along the board on the inner side of the leg. This long bandage is tied to the other encircling strips as it passes them and is finally tied to the highest strip on the inner side.

G. Such a splint supports firmly any injury below the knee joint.

Combined Injuries

I. Upper Extremities

A. Use the splinting methods described above for each injured part.

II. Lower Extremities

A. Fractures of both thigh and leg in one extremity are splinted with the long and short boards as described in Section B under Hip-Thigh-Knee injuries. Add a second short board along the back of the leg from buttock to heel and tie it to the others. All boards should have some padding between them and the skin. Pressure on any bony prominence, particularly the heel, must be avoided by adequate padding with towels or any piece of clothing.

7. Eye Injuries

1. All conscious casualties should be grossly tested for vision by finger counting at close range for each eye. If partial or complete blindness in either eye is found, the fact should be noted on the casualty record. The fact might become of great importance later.

2. Reasonable effort should be made to assess the condition of the globe when a casualty with obvious injury of the orbital structures is first examined. The lids might not be retractable later.

3. Lacerations of the lids should be treated by gently washing away gross dirt. No attempt to suture should be made under disaster conditions. Lids should be gently closed and held in that position by lightly packing the space between the eyebrow and the cheekbone with moist cotton. An eye pad may then be applied. (An eye pad must not be applied without this splinting of the lids to hold them shut.)

4. Complaint of the scratching of a foreign body may be due only to erosions of corneal epithelium. However, search for a foreign body should be made, provided the examiner is prepared by some experience to carry it out.

5. Instillation of a local anesthetic agent (Holocaine, Metycaine, Butyn, etc.), if available, should precede efforts to remove foreign bodies.

6. Touching of the cornea in any way should be reserved for the ophthalmologist.

7. Those who are experienced should gently rub with a dry cotton applicator the conjunctival surfaces if there be suspicion that tiny fragments of glass or other inconspicuous foreign bodies are embedded.

8. After removal of foreign bodies and irrigation of the conjunctival sac, an ophthalmic ointment of sulfathiazole may be instilled. If pain is severe an ophthalmic ointment containing a Holocaine-like anesthetic agent may be used.

9. In cases of burns of the globe or lids, castor oil may be instilled into the conjunctival sac and may serve the very useful purpose of relieving pain and preventing the sticking together of exuding surfaces. Petrolatum jelly or liquid petrolatum may be used if castor oil is not available.

10. An ophthalmologist or two is assigned to each Sector. It should be possible for personnel to learn at what "B" Station an ophthalmologist may be found. Dispatch serious eye casualties thereto as soon as other circumstances permit.

8. Injuries of Brain

General

1. Injury of the brain may be self-evident from the appearance of the face and cranium. Bleeding from cranial orifices is highly presumptive of brain injury since a trauma sufficient to produce fracture of the skull is almost certain to have injured the brain. Severe ecchymosis of the orbital tissues,

when not accounted for by direct injury of the lids, is strongly suggestive of fracture of the frontal or sphenoidal bones. The misshapen, loblolly cranium affords unmistakable evidence of severe brain injury. However, the sensation of a depression imparted to the palpating fingers by hemorrhagic infiltration of the scalp may be very misleading. Only by radiographic examination can certain diagnosis be made unless crepitus of comminuted bone can be felt.

2. Injury of the brain may also be suspected when the state of consciousness is abnormal. Confusion, mania, stupor, coma, convulsions and paralyses are signs which prompt consideration of brain injury.

3. Although the diagnosis of the cause of unconsciousness may be difficult, disaster circumstances call for the formation of an immediate opinion. If severe injuries be discovered, particularly injuries attended by the possibility of great loss of circulating blood volume, whether by external or internal bleeding, a state of coma may be accounted for by shock. To be sure, cerebral concussion may also obtain. In some cases of doubtful diagnosis, lumbar puncture may be possible and the disclosure of bloody cerebrospinal fluid may prove decisive.

4. When cerebral injury is present the cause of associated shock must be determined. If there be concomitant evidence of much internal or external hemorrhage, the shock may be mostly circulatory and parenteral fluids be in order. On the other hand, the shock may be only neurogenic and fluids should not be given. Observation for even twenty minutes may remove all doubt in differentiating the two kinds of shock. In concussion of the brain, if the patient does not die promptly, the blood pressure rises, the pulse becomes bounding, and the respirations become stertorous. In event of such a development, any intravenous fluids which have been started should be discontinued.

5. The only immediate treatment for severe concussion of the brain is to make sure of an open airway, to maintain a slightly head-up position, and to administer oxygen by nasal catheter. After eight to twelve hours when casualty has been transported to a "B" Station, intravenous blood, plasma, or 50 percent sucrose may be indicated. Lumbar puncture may be considered if there be no escape of cerebrospinal fluid.

6. IN NO EVENT GIVE A NARCOTIC TO A CASUALTY UNDER SUSPICION OF HAVING SUSTAINED A BRAIN INJURY. Moderate restlessness should be tolerated without sedation. It may be due to a full bladder. If restlessness be extreme, use intramuscular injections of Sodium Luminal in small (2 grain) repeated doses.

7. All casualties in coma should be palpated for distended bladder even if there is evidence of incontinence. In case of retention a catheter should be anchored.

8. Severe convulsions demand control by administration of intramuscular or even intravenous doses of Sodium Luminal (Sodium Phenobarbital). Some cases of status epilepticus may be encountered and ether anesthesia be required for control.

9. If coma persists for 24 hours, anchor a Levin tube to avoid the obligation of maintaining fluid intake by intravenous route. Give fluids at the rate of 75 cc. per hour (adults). If casualty survives for 48 hours, make part of the fluid intake nutritive.

10. All severe cases of brain injury should receive antibiotics from the start. Sulfadiazine is even better as a prophylactic against meningitis but its use will entail the usual precautions with respect to kidney block.

Intracranial Hematoma

1. Casualties who gradually develop one-sided weakness with deepening of coma may be suffering from surgically curable intracranial hemorrhage. Such a suspicion may become a conviction if the pupil of the side opposite the weakness is known to have increased in diameter from its immediately posttrauma size. The radiographic demonstration of a fracture on the side of the dilated pupil will support the diagnosis of hemorrhage from a severed middle meningeal artery (epidural hematoma). However, this lesion is usually rapidly progressive and under disaster conditions most subjects will die before diagnosis can be established and operative facilities brought to bear.

2. Subdural hematoma may occur in two ways: (a) As an incident in severe laceration (bursting effect) of the brain, subdural hematoma usually escapes diagnosis because its specific *progressive* symptoms are masked by the *immediate* symptoms of the laceration. Furthermore, operative treatment is futile because the brain injury establishes a too narrow bottleneck for recovery. (b) As a consequence of the rupture of a cerebral vein (surface of hemisphere), subdural hematoma has the gradualness of development which enables its diagnosis. As the condition of the brain is frequently good enough to permit recovery if the compressing blood clot be removed, such cases should be transported to a "C" Station in Marion County (Sunnyside or Billings) where neurosurgical attention may be afforded. (c) It should be remembered that the gradual onset or increase of one-sided weakness may be a consequence of increasing swelling of a contused cerebral hemisphere. In the absence of knowledge that a dilated pupil was not immediately present after the trauma, an exploratory burr hole may be necessary.

Compound Fracture of Skull

Compound fractures of the skull of good prognosis will be encountered. Some of these casualties

will be fully conscious and without evidence of shock. They should be transported to a "B" Station where scalp bleeding should be stopped, and gross dirt be removed, including loose fragments of bone. Gentlest handling of these wounds is necessary to prevent re-establishment of hemorrhage which might be uncontrollable. Clots covering the exposed brain should be left in place. A dry dressing should be applied. Circular bandaging should exert only the slightest pressure. Antibiotic therapy should be started at once. Transportation to an intra-county "C" Station (Sunnyside or Billings) may be deferred for a number of hours.

Importance of Records

In no type of injury is a brief notation of the conditions observed immediately after injury more important. Such notes must necessarily be brief: (a) Cerebrospinal fluid and/or blood from cranial orifice. (b) Estimated diameter of each pupil. (c) State of consciousness. (d) Spasticity or weakness, specifying side.

9. Spinal Cord Injuries

1. Paralysis of both lower extremeties with a level of anesthesia on the trunk indicates certain injury of the cord. If a lumbar puncture shows absence of block, operative treatment is usually contraindicated.

2. If operative treatment of a cord injury casualty is to be undertaken it should be done within a few hours. Under disaster conditions this will not usually be possible.

3. Notwithstanding the poor prognosis for functional recovery in such cases, efforts to preserve life by treating shock should be made.

4. When paralysis of the lower extremities is associated with any degree of numbness or weakness in the upper extremities, the outlook for long continued life is very poor. Such casualties should not be permitted to distract the services of personnel to any extravagant extent. The same sort of consideration should influence the use of plasma, blood, and other agents in scarce supply. Facilities should not be strained to give such cases high priority in transportation. Operative treatment prior to recovery from shock would be fatal anyway.

5. When paralysis is limited to the lower extremeties, transportation to a "C" Station in Marion County (Sunnyside or Billings) should be effected as soon as recovery from severe shock permits.

6. In all cases of cord injury, a catheter should be anchored as soon as the diagnosis is made. Nondangerous doses of sulfathiazole should be ordered in prophylaxis of urinary tract infection.

10. Radiation Injuries

The extent of the area around an atomic bomb explosion in which survivors may have received a serious amount of radiation or in which rescue workers should observe precautions to protect themselves from radioactive dust will be determined by monitoring devices. There will be large areas in which casualties may be rescued, and in which rescue workers may work for limited periods of time without harm to themselves.

Workers within the above mentioned zones should be clothed as heavily as the weather will permit and should work with gloves on at all times.

As a rule-of-thumb, casualties taken from a zone within one mile of ground zero should be considered as seriously radiated. Their clothing should be removed as soon as possible and they should bathe, preferably with a detergent.

One of the most important items in the early diagnosis of possible radiation injury is the determination of the location of the patient in relation to ground zero at the time of the explosion, and the approximate amount of shielding which was present at that time.

The medical tag of each casualty should carry a note as to his location at time of injury. Later when ground zero and the radiation potential of the explosion have been determined, this information may be converted into a probable diagnosis of slight, severe or fatal radiation injury.

No first aid treatment of radiation injury is possible or necessary during the first 24 hours.

All efforts should be made in the first 24 hours to determine the casualty's radiation status. Much of this work can be done by nonmedical personnel.

Casualties from a zone within one mile of ground zero should be put at complete rest.

Rescue workers and first-aiders will be informed by monitoring squads in regard to areas in which they may work safely for limited periods of time. Information will also be given as to the necessity of having workers discard their clothing and bathe after leaving certain areas.

REFERENCES

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EQUIPMENT AND SUPPLIES

ONE of the most difficult problems of Civil Defense is that of equipment and supplies. Nation-wide equipment of dressing stations and emergency hospitals is obviously inconsistent with the overall national defense effort. States, counties, and municipalities could not afford such a huge undertaking.

The proposition that stock piles of equipment and supplies be established by the Federal Civil Defense Administration at points capable of serving groups of target areas is open to the criticism that hours would be required to bring materials up to any one distressed area.

The committee of the Indianapolis Medical Society offers reliance upon many, highly dispersed, small stock piles as a partial solution of this problem. At the time of disaster supplies for the very critical first few hours could be drawn from the following sources:

1. The emergency medical kit each doctor is requested to provide for himself and to carry at all times in his personal car. If he has two cars, it is hoped he will provide another emergency kit for the second car which would be less likely to suffer destruction in a disaster. (See Schedule (a) in this section.)

2. The modest stock pile of supplies (costing from $50 to $100) which many doctors and others living in the outskirts have volunteered to store in their homes and produce when necessary. (See Schedule (b) in this section.)

3. The kits of medical supplies which the druggists of Marion County have volunteered to set aside and maintain in fresh, usable condition. (See Schedule (c) in this section.)

4. The augmented inventories of supplies maintained by the hospitals of Indianapolis and of the surrounding rings of mutual aid supporting counties. The committee is requesting itemizations of the stocks ordinarily maintained and estimates of possible increases up to 25 per cent. Even though the hospitals of Indianapolis should be thrown out of service by an atomic bomb, it is probable that much of their supplies could be salvaged for use in the treatment stations. By the same token, supply houses, warehouses, etc., would not all be utterly destroyed and can be counted upon for rather immediately available supplies.

5. The household emergency medical kits which the public have been requested to install in their homes (the kits humorously referred to in May 12 *Collier's Weekly* as "hope-not chests"). These could be counted upon to assist in cushioning the perilous delay in bringing up large supplies from official stock piles, if such should ever be provided by FCDA. (See Schedule (d) in this section.)

6. The blankets, sheets, table cloths, towels, napkins, et cetera, which every home could be expected to contribute to neighboring treatment stations constitute a huge stock pile already at hand of material for dressings.

7. Laboratory equipment sufficient to set up four emergency laboratories is expected to be obtainable by contribution of items as well as by appropriation. Such equipment will be packed in cases and stored on location so as to be ready for almost immediate service. Physicians and agencies who can contribute pieces of laboratory equipment are requested to *write* to Dr. Horace M. Banks, Methodist Hospital. Items such as centrifuges, microscopes, hemacytometers, incubators, water baths, laboratory thermometers, Bunsen burners, spirit lamps, Coleman lanterns and stoves, et cetera, may be scattered throughout the community in places where they are no longer being used. (See Schedule (e) in this section.)

8. "B" Treatment Station equipment. Actual predisaster storage in safe places of certain bare necessaries for emergency hospitals is being planned. The general public will be asked to contribute such items as kerosene lanterns, gasoline lanterns and stoves, pieces of hospital equipment once used but no longer needed, vessels for boiling instruments, crutches, folding cots, et cetera. The American Red Cross may find it possible to store equipment at peripherally situated safe points designated by the committee.

9. Doctors and hospitals in the central Indiana target region are herewith requested to contribute surgical instruments which are no longer used but which are still usable in an emergency. Each Indianapolis hospital has been requested to provide a place for the collection of these contributions. From the entire collection kits will be arranged and stored in peripherally situated "B" Treatment Stations. Funds may become available for the purchase of enough instruments to piece out such kits into practical units of equipment.

SCHEDULE (a)
Emergency Kit for Doctors' Cars

1. Flash light with extra batteries
2. Large size bandage scissors
3. 1 pair suture scissors
4. 1 doz. "Dermalon" plastic sutures with needles
5. 1 doz. atraumatic catgut sutures with ¾-inch needles
6. 2 doz. tubes plain catgut No. 1
7. 6 hemostats
8. 1 pair thumb forceps
9. ¼ pound sterile cotton
10. Rolls of gauze: 6 rolls 1-inch; 6 rolls 2-inch

11. Adhesive tape, 5-yard rolls: 1 roll 1-inch; 1 roll 2-inch
12. 4 doz. Bandaids
13. 4 doz. Readipads
14. Bard Parker handle with blades
15. 2 doz. tongue blades
16. 4 doz. cotton applicator sticks
17. 6 oz. bottle Tr. Merthiolate or equal
18. 6 oz. bottle S. T. 37, Aqueous Merthiolate, Zephiran, or equal
19. Morphine, because of risk of robbery by addicts, should not be included in ¼ grain Syrettes or in ¼ grain hypo tablets. Kits should bear label "No Narcotics."
20. 3 oz. bottle 1% Novocain with Adrenalin
21. Syringe, 2 cc., 5 cc.
22. 6 hypo needles, 25 gauge, ½-inch
23. 3 bars "surgical" soap. (Gamophen or equal)
24. 1 doz. ampoules Sodium Luminal
25. 1 ether mask and 1 can ether
26. 6 tubes ophthalmic ointment, White's or boric
27. 4 oz. aromatic spirits of ammonia
28. 1 old belt or strap for tourniquet
29. 1 doz. paper drinking cups
30. 1 doz. basswood splints, 3½ by 30 inches
31. 1 skin marking pencil
32. 1 doz. medium and 1 doz. large gauze-faced cellulose dressings
33. Supply of casualty tags when same are provided

SCHEDULE (b)
Home Stockpile of Emergency Materials

1. Fine-mesh gauze, 2 bolts
2. Unbleached muslin, 1 bolt
3. Safety pins, 1 carton of cards
4. Yucca board splints, 3½ by 30-inch, 3 doz.
5. Waxed paper, 1 doz. rolls
6. Chlorinating tablets for drinking water, 500
7. Mechanics' waste, autoclaved, 6 bundles
8. Faced cellulose dressing pads, 6 doz.
9. 6-inch stockinette, 6 rolls
10. 2, 3, and 6 inch gauze in rolls, 1 doz. of each
11. 2 balls of twine
12. "Readipads" or equal, 1 doz. boxes
13. Rubbing alcohol in bottles, 6 pints
14. Persons who purchase and store any considerable portion of this list of supplies are requested to report their inventories to the Civil Defense Committee of the Indianapolis Medical Society.

SCHEDULE (c)
Rotating Medical Supplies in Kits Maintained by Druggists

Members of the Indianapolis Retail Druggists' Association who are maintaining a revolving inventory of supplies for Civil Defense purposes are instructed as follows:

Follow the advice of Mr. A. C. Fritz, Secretary of the IRDA, who will direct the druggists enlisted in Civil Defense.

Keep the materials specially provided for Civil Defense use in a chest or trunk which is both easily accessible for routine withdrawals and replacements, and readily transportable to a Treatment Station.

A list of the contents should be firmly attached to the outside and inside of the cover.

The emergency chest should be conspicuously labeled in a permanent fashion. It should be kept in a conspicuous place, in view of customers. A special stick-on label will be provided by the Indianapolis Medical Society.

On the front or the top of the chest should appear the words "NO NARCOTICS." The chest should not be padlocked.

Druggist Kit for Treatment Station

(Items will be selected by the IRDA in quantities to make a one hundred dollar kit)

A. Antibiotics

Penicillin
Aureomycin
Chloromycetin
Terramycin

B. Biologicals

Pituitrin
Pitocin
Adrenalin

C. Drugs in Ampoules

Caffeine Sodio-benzoate
Coramine
Novocaine
Gynergin
Glucose, 50% Solution
Sucrose, 50% Solution
Sodium Luminal
Atropine sulphate
Crystidigin

D. Drugs in Bulk

Rubbing alcohol—pint bottles
Tr. Merthiolate—½ pint bottles
Hydrogen peroxide—½ pint bottles
Petroleum jelly—1 pound jars
Castor oil—½ pint bottles
Holocaine type ophthalmic ointment in tubes
Boric ophthalmic ointment in tubes
Holocaine type sol.—1 oz. dropper bottles
Sodium chloride tablets
Water chlorinating tablets
Acetyl Salicylic Acid Tablets—5 grain
Phenobarbital tablets—1½ grain, scored
Phenacetine tablets—5 grain
Hypo tablets, Atropine sulphate, 1/150 grain
Sulfadiazine Tablets—0.5 Gram
Sulfathiazole Tablets—0.5 Gram

E. Supplies

Hypodermic syringe, 2 cc.
Hypodermic syringe, 5 cc.
Hypodermic syringe, 50 cc.
Hypodermic needle, No. 18

Hypodermic needle, No. 20
Hypodermic needle, No. 22
Clinical thermometer
Catheter, No. 14
Catheter, No. 16
K-Y Jelly in tubes
Ace bandage, 3 inch
Rolled gauze, 2 inch
Rolled gauze, 3 inch
Rolled gauze, 4 inch
Gauze squares, folded, sealed
Aseptic cotton, ¼ pound boxes
Cotton applicator sticks
Wood tongue blades
Adhesive tape, 2 inch, 10 yards

SCHEDULE (d)

First-aid Kit Recommended for Household Storage "Hope-Not Chests"

The following recommendations were published in an Indianapolis newspaper in March, 1951:

A fairly waterproof container should be found. A large tin lard can will suffice. In the bottom should go those items not likely to be needed except in event of disaster. On top should go those items which are frequently necessary in the care of small daily casualties. When such items are used, they should be immediately replaced to keep the kit fully equipped against disaster. Following is the list of recommended items:

1. A large candle (Plumbers' type preferred)
2. A sealed box of safety matches
3. A folded sheet
4. A folded blanket tied around the lard can
5. A bottle of 100 tablets sold for chlorinating drinking water
6. A roll of waxed paper for covering burns
7. A paper of safety pins
8. Six paper drinking cups
9. A bar of soap, preferably "surgical," similar to "Gamophen"
10. A square of muslin, 36x36 inches, for a sling
11. An old belt or strap for use as tourniquet
12. An elastic bandage, not rubber, 2 to 3 inches wide, 5 yards
13. Flashlight with extra batteries
14. Large scissors for cutting bandages
15. Cotton applicator sticks, 1 doz.
16. Wooden tongue depressors, 1 doz.
17. Aromatic Spirits of Ammonia, 2 oz.
18. Boric Ointment for eyes, 1 tube
19. Tincture Merthiolate (or equal) 3 oz.
20. Petroleum jelly, ¼ pound.
21. Sterile cotton, ¼ pound
22. Rolled bandage gauze, 1 inch wide, 2 rolls
23. Rolled bandage gauze, 2 inches wide, 2 rolls
24. Sterile gauze squares in sealed envelopes, 1 doz.
25. Adhesive tape, 1 inch wide, 5 yards.
26. "Band-Aids" or their equal, 3 doz.

SCHEDULE (e)

Laboratory Station Equipment

A complete list of essential equipment is on file. It comprises items in the following categories:

1. Blood typing and compatibility testing equipment
2. Equipment for hematology
3. Equipment for urinalysis
4. Equipment for simple bacteriologic work

The United States is beset with a terrible danger of which most people seem totally unaware or which they conveniently overlook. We are in danger of enemy attack on our cities and towns. Science and technical advancements in aviation have made this more than a remote possibility.

Fortunately for the people of Indianapolis and Marion County there are certain far-seeing men and women and groups who are doing something about the problems that face us in this time of crisis. The medical profession and its allied professions have come to the front almost to a man, and the Civil Defense Medical Divison has organized a detailed plan that will save countless thousands of lives should we ever be attacked. We in Civil Defense think that it is one of the best operational plans in the United States today.

The credit for this accomplishment goes to the doctors, dentists and nurses who have given freely of their time in organizing this plan. I think we can sum up their participation in Civil Defense by saying that their work has been in accord with the finest traditions of the medical profession.

CHARLES R. BRODERICK, *Defense Director*,
Marion County Department of Civil Defense
and Disaster Relief

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POSTSCRIPT

THE Indianapolis Medical Society Civil Defense Committee offered to THE JOURNAL this study of the defense problem of the *Central Indiana Target Region* with realization of the incompleteness of its plans. Publication at the present time was prompted by information, available to everybody, alerting us to the possibility of surprise attack yet this summer. Incomplete and tentative plans are better than none at all.

Furthermore, it is questionable whether completeness can ever be achieved. There seems to be no limit to the distressing contingencies which must be considered by the student of Civil Defense. Their contemplation in realistic terms requires the overcoming of stubborn emotional resistances because our habitual modes of thinking no longer suffice. We are forced to engage in the ugliest kind of fantasy. But even if completeness of planning be an unattainable ideal, it must be striven for. Society needs to regain, by energetic preparation, some feeling of relative security.

For how long should we strive? Some say Civil Defense must be looked upon as a ten year program. If only the duration were but ten years! A glance at the causes of this hateful burden cannot fail to convince us that *interior* Civil Defense will be an obligation as long as we must provide for *exterior* National Defense.

The invention of long-range aircraft and of atomic bombs has done this to us. Inventions cannot be undone. As long as any group, devoted to imposing its will upon us, is able to commandeer the resources of a great country and connive behind an "iron curtain" at our subjugation, we shall be compelled to maintain a Civil Defense—or capitulate.

To be sure, we may wish for and imagine improbable escapes from this dilemma. We may pin our faith upon the spontaneous dissolution of the malevolent design against us. Or we may fondly expect to prevail over it by moral and spiritual suasion. Or we could, if we dared, entertain a possibility currently considered too unholy to utter or even to think: plan aggressive action to exterminate the authors of the aggression directed against us.

But, however the dice be thrown by Time, the immediate establishment and indefinite maintenance of Civil Defense is imperative for fulfillment of our highest biological responsibility—to survive as individuals and as a society.

The method of providing Civil Defense is not entirely settled. We know that the Department of National Defense has rejected responsibility for it because its hands are already sufficiently employed. The newly created Federal Civil Defense Administration can provide us with logistical information, suggestions for procedure, and perhaps some supplies. But it lacks the man power to carry a single litter or dress a single wound. It will continue to be relatively powerless in action unless this country should be converted into a police-state with all its citizens under orders and bound by discipline such as prevails in the armed forces. Since this option is too hateful to contemplate, Civil Defense, unlike National Defense, must be organized from voluntary services and must depend, largely, upon volunteered materials. Not orders from above, but rather the initiative of the people, must provide the driving force.

On the state and county levels the Civil Defense pattern which has been evolved to this date imposes heavy responsibilities upon the public health departments. These governmental agencies, however, cannot cope with the emergency medical treatment problem without an enormous and costly increase in their employed personnel. Thus, the voluntary services of medical societies all over the country would appear to provide the healthiest solution of the treatment and rehabilitation phases of the Civil Defense problem. Vigorous response to this challenge by physicians everywhere should remind the public of the profession's spirit of service and of its readiness for independent action.

E. V. H.

WATCH

for announcement of Instructional Programs relating to Chemical, Bacterial and Bombardment Warfare from within (sabotage), as well as Atomic Warfare from without.

THE JOURNAL

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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CIVIL DEFENSE ISSUE

THIS issue of THE JOURNAL is devoted to the civil defense medical plan of the Indianapolis Medical Society. The plan is published in its entirety as an example of the detailed planning which is necessary to implement the basic principles of medical service in a catastrophe.

It will be one of the first such complete plans to be published, and is presented as one method of accomplishing emergency coverage for a large disaster.

The plan has been based on the general principles outlined in "Health Services and Special Weapons Defense" as published by the Federal Civil Defense Administration.

Each target area in the United States differs from the others in some particular, and the medical plan for each area will likewise differ. Geographical considerations, the locations of permanent medical facilities, distribution of the population and the character of the surrounding territory will all influence the methods to be adopted by any one area. The general principles will be uniform for the entire country, but the operational procedures will vary.

Medical planning of this type will be continuous in order to take advantage of medical advances and to adapt the plan to possible changes in the type of attack which is expected. The staff of THE JOURNAL believes that this is one of the most important functions of the medical profession at the present time. It is hoped that other types of medical plans, and improvements and advances in medical planning may be reported and discussed on these pages in the future.

SIMPLIFIED TREATMENT PLANS

A SIMPLIFIED treatment plan is an important part of any medical plan designed to care for thousands of casualties, for the following reasons:

1. For procurement of supplies and equipment. Since stockpiling will be severely limited, it is essential that only the most important items be procured. A treatment plan will aid in determining what supplies are of prime importance.
2. For training of lay volunteer workers. These individuals should be trained by the thousands. It is essential, not only to teach them how to apply tourniquets and splints, but also to indoctrinate them in the basic principles of the therapy of trauma.
3. For refreshing of doctors who are not ordinarily engaged in treatment of casualties.
4. For training of professional groups such as dentists, nurses and technicians.
5. As a reminder to everyone that, in order to care for thousands of casualties, it is necessary to reduce treatment to the barest essentials.
6. To prescribe and authorize improvised methods and substitute materials.
7. To prescribe a plan for the movement of casualties so that nontransportables are subjected to movement as little as possible.
8. To prescribe a system of priorities in the treatment of casualties, which will postpone treatment of those who can wait without harm in order that immediate treatment may be available for those who would die without it.

LAY MEDICAL WORKERS

THERE are not going to be enough doctors to go around if an atom bomb falls.

There will be an enormous number of casualties, possibly as many as several hundred severely wounded people per doctor.

It will be impossible for doctors to conduct all the first aid work; it will also be impossible for them to conduct all the medical treatment.

By careful planning and training beforehand we can build up a corps of lay volunteer assistants who will be able to complete the large number of treatment teams that will be necessary.

Lay assistance for actual medical work is not all that will be required. Thousands of trained workers will be needed for the operation of temporary hospitals. This will include all the types of duties ordinarily performed by laymen, such as cooks, janitors, clerks and orderlies. It will also include trained lay workers to help with work that is ordinarily performed by professionals such as nurses and laboratory workers.

The ordinary ratio of hospital attendants today is one hospital employee to each patient. It is reasonable to suppose that under improvised and cramped conditions, and with few supplies, disaster hospitals will need at least as many helpers as there are patients, and possibly more.

There will be many former members of the medical departments of the Army and Navy who will need very little or no training. As they volunteer they may be assigned to medical stations and hospitals, and some of them may make use of their talents by instructing previously untrained laymen.

One of the characteristics of the medical plan for civil defense is that almost everything that has been advocated so far should be done whether an atom bomb is likely or not. The community should have an emergency medical plan to care for all types of disasters. The populace should be immunized with tetanus toxoid, atoms or no atoms. Homes should be supplied with first-aid kits for everyday use.

Likewise, all our citizens should have some education in home nursing and in emergency medical care. They should be encouraged to obtain such training in large numbers. If we are never tagged by an A bomb, the training will not be wasted.

CONTROL OF PANIC

ATOMIC explosions produce four main effects: blast, fire, radiation and panic.

In some ways the panic which would be produced by an atomic attack on an unprepared community might be the most troublesome effect of the four.

The citizens of London during World War II proved that an entire population could be trained and conditioned to such an extent that heavy conventional bombing did not force abandonment of the city. On the other hand, the Germans, who had been deprived of such predisaster preparation because they did not admit the possibility of bombing, suffered much more than did the English.

Preparations made to minimize destruction and plans made for relief of the injured are certain to be very effective in controlling panic. As Civil Defense plans are formulated and improved, as more and more citizens are trained in first aid, and as more and more citizens are trained in damage control and in rescue work, the less likely will be the development of panic in the event of a large scale disaster of any nature.

The ultimate objective would be to have disaster plans so advanced in detail that every adult would have a definite assignment of duty in case of a catastrophe.

Such plans and preparations cannot be made all at once. Improvement of the Civil Defense organization will be a continuing process. With the passage of time and by virtue of hard work, large numbers of people will be trained, and the efficacy of the organization will be enhanced.

Reprints of the Civil Defense Articles in this issue (36 pages) are available at 35c per single copy; 25c per copy in lots of 100 or more.

Reprints of the Simplified Treatment Plan only (pages 472 through 482) are available at 25c per single copy; 15c per copy in lots of 100 or more.

President's Page

SOME THOUGHTS UPON REACHING A GREAT MILESTONE

ON APRIL 28 it was my privilege to be invited to address the senior class of our medical school. In preparing for this talk it occurred to me that I should say to these young men and women the things which you doctors of Indiana would want me to say to them. It was realized that within an hour one could hardly reveal all the hopes and aspirations and counsel that each of us feels in his heart for these young people who are about to embark upon their professional careers.

First they were told that every doctor of our association extends his congratulations upon their approaching this great milestone. The brilliant accomplishments in the science of medicine were then briefly reviewed, emphasizing to them that the doctors of yesteryear had no x-ray or wonder-drugs but were dependent upon developing an intuitive diagnostic ability and much common sense in the treatment of their patients. It was pointed out that in that day patients almost universally loved their doctor because he had the time and disposition to be kindly and to have a personal interest in their troubles. Then it was pointed out that simultaneously with our age of specialization in medicine there has occurred changes in the ethical and moral concepts held by most everyone. The basis of this, of course, is communism with its philosophy of materialism versus Christianity. This philosophy has been spread into every corner of the world and has affected everyone of us to some degree. I reminded these students that doctors were no different from other people and that we too had fallen prey in some degree to these influences. The people, they were told, have tremendous respect for our scientists and research men and their accomplishments, but the warm feeling once held for our practitioners is waning.

The framework of medical organization was explained to them. It was pointed out that no organization in the country is more democratic than ours. They were reminded that the county medical societies have complete authority to determine their own membership and that membership in one's local county society was necessary before one could be a member of his district, state and national medical organizations.

Some of the benefits which would be theirs from belonging to their medical organizations were described. To be a member of one's county medical society brings the recognitions that every human being should appreciate, namely, the approval of his fellow practitioners, of the hospitals, of the public, of various other organizations of doctors, and lastly, the knowledge which he and his family will cherish in knowing that he "belongs." It was pointed out that by joining together we can oppose the forces of socialism, aimed not only at our own profession, but aimed at everything which real Americans hold dear. They receive The Journal of the Indiana State Medical Association which is acclaimed as second to no other state medical journal in the nation. They have the privilege of joining together in the meetings of their county society, their district society, the state and American Medical Associations. These meetings afford the opportunity for graduate education and also that very important opportunity for fellowship. The advantages of our telephone postgraduate educational courses were explained to them, as was the right to legal aid in case of need. And lastly, medical organization provides the medium through which each doctor may serve the cause of medicine and humanity by working on various committees and projects.

Each was urged to be a good doctor scientifically and to be an ethical doctor, saying that medicine is too fine and has too glorious a history to be debased by commercialism. They were urged constantly to be alert to protect medicine from its enemies, saying to them that we would have had government medicine years ago if medical organization did not exist. They were advised to be jealous of medicine's reputation and were reminded that some of our worst enemies are within our own ranks. Their attention was called to the fact that we are quasi public servants and that medicine is a way of life rather than a way to make a living. They were reminded that for every dollar each of them contributes to the medical school the taxpayers add a considerable sum from their pockets.

And finally, I presumed to give them some advice. The larger cities have attracted a disproportionate number of doctors with the result that not all are as prosperous as they would like to be. The advantages and pleasures of living in the smaller communities of Indiana, where the real need for more doctors often exists, were emphasized. They were urged to take an active part in their community life and to take an active part in political life of their community and to learn to speak well in public, for doctors of the future will surely need able spokesmen for their cause. They were advised to recognize that many of the national organizations which are allied with medicine such as the Cancer Society, Tuberculosis Association, Red Cross are here to stay and are here because there is a real need for them. To join them and guide them and offer our assistance is a most desirable thing to do. They were urged to discuss with their patients the contemplated costs of expensive procedures such as surgical operations or extensive diagnostic procedures, and to follow the Golden Rule in keeping their charges within the patient's ability to pay. Then I said to them that in dealing with their patients learn to smile and to have a genuine interest in their welfare, that most of us little realize the complete dependence and faith our patients place in us. A man who takes good care of those who entrust their welfare in his hands need not have any worry about his career. The best way to retain the private way of life in medicine is to do such a good job for our patients that they will not listen to our critics. If every patient leaves his doctor firm in the belief that he has been fairly and honestly treated, the problems of government medicine will be solved. And finally I urged each of them to so conduct his practice and his career as to pass on the wonderful heritage which has been handed to us by the great doctors of the past.

It is hoped that these are some of the things you would have had me tell these young doctors.

Alfred Edison

Medical Panorama by the Associate Editor

THE VA PURGE

In *New York Medicine*, for February 5, 1951, is a rip-snorting, yet dignified editorial on "Dr. Magnuson and Mr. Gray." It first reviews the question as to whether the doctor resigned or was "fired," and concludes that regardless of this, "Mr. Gray was dissatisfied with his medical director and vice versa. Dr. Magnuson has said 'General Gray has a very low opinion of doctors as administrators. Well, I have a very low opinion of administrators as doctors.' "

There follow some paragraphs on the Board of Chief Medical Consultants as distinguished and independent men, who "have battled, at times vigorously, with the medical director on strictly medical matters."

From there let us quote more fully:

The work of improving the medical care within the Veterans Administration has progressed remarkably under Dr. Magnuson's administration. This achievement has been the joint accomplishment of Dr. Magnuson and his board of consultants who have argued through the many problems that have revitalized medical care within the VA. All this is mentioned to set the record straight and to show that the support of the medical consultants for Dr. Magnuson is no mere backslapping gesture from members of the same lodge.

Rather, the support is a straightforward recognition of an outstanding physician who is a good administrator and who has now been replaced in the current purge. And purge it was. By decree and in secret.

As a matter of fact, even Mr. Gray's own private medical advisory board did not know about it. This advisory group to the administrator of VA is a logical and legitimate check on any activities which Dr. Magnuson might have carried out. It is extremely significant that Mr. Gray, the administrator, did not request the advice of his own medical advisory board, before dismissing his medical director.

* * * *

Yet, the whole episode should have its future benefits, even if Dr. Magnuson is the current victim. Note the parallelism between the fight in the VA and England's system of medical care where a lay administrator—not a physician—has been Minister of Health. Until just a few weeks ago the top man to see in England, if one was sick, was the Honorable Aneurin Bevan. He had complete control over medical care and over hospital administration.

Mr. Bevan has moved onward and upward in power and has been replaced by a new Health Minister, Mr. Hillary A. Marquand, who will have curtailed powers and no seat in the Cabinet. But it is still true in England that what a doctor decides in medical matters means little for he can be overruled by civilian lay boards and, as a court of last resort, by the Minister of Health himself who is again a layman and a politician.

For the future note too—and mark this well—that the current situation in the VA is probably a prototype of the administrative difficulties to be encountered if and when national compulsory health insurance becomes a reality in America.

* * * *

The danger and the risk which physicians fight, against centralized control of medical affairs in Washington, is the realization that no matter how the project is presented, it all adds up to one word which explains much about the troubles of the world today. That word is power. One may congratulate Mr. Gray in the present VA fiasco for providing the current prize example of government administrators seizing power. Thank you, Mr. Gray.

Congratulations to you, Dr. Magnuson.

It is a sad day for medicine when it becomes embroiled in contests for personal power, but it will be sadder still if we ever reach such an ebb that we either give up the fight or fail to see danger as it threatens. Threats come even from our own ranks, as witness Dr. Ernst P. Boas, and as a little postgraduate course we suggest you read Dr. Austin Smith's editorial in the *Journal of the American Medical Association* for January 27, 1951, entitled "As a Man Thinketh," in answer to such attacks.

AN 'OSCAR' FOR OSCAR?

Once again Oscar Ewing's Federal Security Agency has presented an annual report to Congress in which Mr. Ewing says that now, in the midst of war and defense preparations, is the time to enact compulsory health insurance and other forms of Federal social insurance. Mr. Ewing has a talent for ineptitude. His socialized medicine views were roundly rejected by the American people during the last campaign. He has angered the people of Indiana and other states by his futile attempts to threaten our State Legislature into obedience to his wishes on the welfare secrecy bill. What is he trying to do, anyway, win an "Oscar" for being the dumbest Hoosier in Washington?

—*Indianapolis Star*

I will never be for socialized medicine until I am for socialized newspapers.—*Louis B. Seltzer, editor, The Cleveland (Ohio) Press.*

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

HOSPITAL BATTLE

A battle is being fought today between hospitals and doctors throughout the nation that may make hospital care more costly, states an article in a current magazine.

On one side are doctor specialists who do all or most of their work within hospitals. On the other side are the American Hospital Association and allied professional groups.

Here is the crux of the problem:

When you are a hospital patient in a large institution, you may be sent to the X-ray department for examination by a medical specialist known as a radiologist. A specimen of your blood or tissue may be sent to a laboratory to be examined by a pathologist.

These doctors are called "auxiliary specialists," and are usually paid by the hospital.

Charges for such auxiliary services are usually included in the general hospital bill.

But some medical organizations are demanding a change. They have given hospitals an ultimatum: take your auxiliary specialists off salary; let them bill patients directly.

In explaining this stand, Dr. George F. Lull, general manager of the American Medical Association, says: "Any doctor who splits fees with a hospital is guilty of unethical conduct and is liable to be expelled from his medical society. When a hospital nets $50,000 from a pathologist's department and pays him only $15,000, it is making a profit of $35,000 and exploiting the doctor to that extent."

But hospitals for the most part are operated on a not-for-profit basis for the benefit of the public. Many are in the red at the end of the year.

If the doctor-hospital feud should degenerate into an all-out fight, the hospital patient would be the chief victim. Patients already chafing under high medical costs may find it to their interests to take up this fight, in hospitals where the proposed plan would increase the cost of hospital care.

—Sullivan Times

A MIRACLE NOT POSSIBLE UNDER SOCIALISM

The press recently featured the amazing case of a Negro woman who was found frozen in a Chicago alley in a condition which bordered on rigor mortis. Her body temperature, pulse and respiration were all so low that it seemed impossible that she could survive—no one in a similar condition ever had. However, skillful and unremitting work by doctors, nurses and hospital attendants resulted in a miracle—the woman lived. She has since lost some limbs, but she did live.

An unusual comment on the matter appeared shortly thereafter in the Arkansas State College newspaper, which said, "To us in the United States, this case appeals mainly as another wonderful accomplishment of modern medicine, but in countries with socialized medicine, the citizens are struck dumb at another miracle. This miracle is the time consumed by the hospital staff on one patient."

In socialized medicine countries, doctors and nurses are plagued with insignificant cut and bruise cases and innumerable neurotics who must be cared for under penalty of the law. Each patient is allotted a certain amount of time. Hospital staffs cease to take a personal interest in their patients and haven't the time to care for the patients as individuals.

Although the medical profession in our country is accused of being mercenary, and some arguments can be given to support these accusations, socialized medicine is not the cure. Usually, the bigger and more important the doctor, the more time he will take with each case. Some of the smaller men have a lot of patients and don't take the time with each that they should, or don't take the personal interest that they should in each case. They need more help, more men should be approved for entrance into our medical schools—we can use thousands upon thousands more before these now practicing will even be relieved of that part of their practice which is regarded as "too much" or that part which over-burdens them and causes them to be too busy to give more personal attention to each case.

In other words, medicine is one place where the mass-production idea does not fit. We must never destroy that fine relationship between doctor and patient which has been built up so painstakingly under our system of free medicine.

—Tell City News

Deaths

Fred R. Clapp, M.D., of South Bend, died after a long illness on April 28, at the age of seventy-one. He was the last surviving charter member of the South Bend Clinic, and was the first physician to specialize in obstetrics in South Bend. Doctor Clapp graduated from the Rush Medical College, in Chicago, in 1903, and practiced in Ligonier before going to South Bend, thirty-five years ago. He retired in September 1949, because of ill health. He was a member of the St. Joseph County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

George L. Gibbons, M.D., retired physician, died on April 12 at his home in Mitchell. He was seventy-three years of age. He was a graduate of the Central College of Physicians and Surgeons, in Indianapolis, in 1903, and practiced in Huron until 1909, when he moved to Mitchell, where he practiced continuously until his retirement.

Bernard A. King, M.D., of Anderson, died on April 25 in Miami, Florida, at the age of sixty-nine. He was a 1905 graduate of the Medical College of Indiana, in Indianapolis, and began the practice of medicine in Cicero. He served with the Army Medical Corps during World War I, following which he began the practice of medicine in Anderson, where he had practiced for more than thirty years. Doctor King was a member of the Madison County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Nils S. Lindquist, M.D., retired physician of South Bend, died suddenly on April 29, at the age of seventy-six. He graduated from the Hahnemann Medical College and Hospital, in Chicago, in 1899, and opened an office for the practice of medicine in Plymouth. In 1909 he moved his office to South Bend, where he practiced until his retirement in 1945.

Austin D. Sweet, M.D., of Martinsville, died in Indianapolis on April 22, after a long illness. He was fifty-six years old. He was a 1923 graduate of Indiana University School of Medicine, and had practiced in Martinsville since that time. Doctor Sweet was a veteran of World War I.

William Ernest Wilkin, M.D., of South Whitley, died on April 16, at the age of seventy. He was a graduate of Barnes Medical College, of St. Louis, in 1904, and began his practice in Illinois, moving to South Whitley in 1922.

NARCOTIC LICENSE

Physicians currently registered under the Federal Narcotic Law must file with the Collector of Internal Revenue in whose district they practice Form 678 (application for registration or re-registration), together with an inventory of the narcotic drugs on hand, copies of which inventory are attached in duplicate to Form 678, and pay the tax of $1.09 on or before July 1, 1951. A copy of this inventory form must be kept for a period of two years.

In a circular dated November 24, 1950, issued over the signatures of Mr. George J. Schoeneman, Commissioner of Internal Revenue, and Mr. George W. Cunningham, Acting Commissioner of Narcotics, Forms 678-A (application for registration by new applicants) and Form 713 (inventory of narcotic drugs on hand) have been eliminated from the regulations. The oath as required by Article 9 of Regulations No. 5 is no longer required. Also the sworn statement concerning the loss of narcotics as contained in Article 194 of Regulations No. 5 is no longer required. In lieu of a sworn statement, a registrant may now submit a statement of his loss of narcotics over his own unsworn signature.

The Bureau of Narcotics has issued a warning that official government forms, prescription pads and supplies of narcotic drugs should be securely safeguarded against theft.

INDIANA STATE BOARD OF HEALTH
Division of Communicable Disease Control

MONTHLY REPORT—MARCH, 1951

Disease	Mar. 1951	Feb. 1951	Jan. 1951	Mar. 1950	Mar. 1949
Brucellosis	1	1	0	2	3
Chickenpox	357	358	367	283	561
Diphtheria	12	2	5	16	32
Encephalitis	3	2	0	1	2
Erysipelas	3	1	0	1	1
Impetigo	2	1	1	0	1
Influenza	74	64	51	113	40
Infectious hepatitis	38	11	4	0	0
Malaria	1	0	0	0	1
Measles	1235	624	211	1112	572
Meningitis,					
Unclassified	8	5	7	6	3
Meningococcal	3	3	5	3	2
Mumps	339	182	167	195	184
Pneumonia	64	42	54	71	60
Poliomyelitis	4	4	5	4	3
Rabies in animals	37	49	19	30	75
Rheumatic fever	1	5	1	1	1
Rubella	71	12	8	79	85
Scarlet fever	313	233	178	326	394
Septic sore throat	8	0	8	0	9
Tinea capitis	2	5	5	0	19
Tuberculosis,					
Pulmonary	221	135	141	175	171
Other forms	15	9	13	17	19
Typhoid fever	4	4	2	3	5
Vincent's angina	2	1	0	1	0
Whooping cough	43	97	89	151	73

News Notes

EMERGENCY MEDICAL CARE FOR MILITARY PERSONNEL

Members of the armed services may be given emergency medical care by civilian physicians when military medical facilities are not at hand. Doctors are requested to render whatever services are indicated and to contact the nearest military hospital for instructions as to further care and disposition of the patient. Information in regard to arrangements for reimbursement by the government for the hospital and physician may be obtained at the same time or later. Care of those who are acutely ill and the splinting of fractures prior to transportation are of special importance.

NATIONAL ORGANIZATIONS BRIEFED ON CIVIL DEFENSE PLANS

Representatives of nearly 400 national organizations, including the AMA, were briefed at a two-day meeting on present status and future plans for civil defense. Federal Civil Defense Administrator Millard Caldwell and other officials asked for cooperation in a broad educational program. Other speakers included President Truman, Defense Secretary Marshall, Vice President Barkley and Governor Warren of California. Earlier, in a letter to the Senate Subcommittee on Securities, Insurance and Banking, Mr. Caldwell requested special legislation to provide compensation for civil defense workers killed or injured in training or in preparations for enemy attacks, as well as during or after raids.

Agreement Reached on Hospital Standardization. An agreement which will do much in settling the prolonged controversy over hospital standardization has been reached by the committees of the four major organizations—the A.M.A., the American Hospital Association, the American College of Surgeons and the American College of Physicians. Since the conclusions will have to be presented for approval by all of the parent bodies it is doubtful if the new program can take effect before January 1 of next year.

When all four parent bodies have approved the program, which calls for a new plan on accreditation of hospitals, a joint statement will be issued, giving all the details.

The agreement was reached at the sixth of a series of conferences that started last August.

—*A.M.A. Secretary's Letter.*

GENERAL ARMSTRONG APPOINTED SURGEON GENERAL

Major General George E. Armstrong was recently appointed, subject to confirmation by the Senate, Surgeon General of the Army. General Armstrong is a graduate of Indiana University School of Medicine and has been a medical officer since he received the M.D. degree in 1925.



During World War II he was deputy chief surgeon of the China-Burma - India Theater, and was surgeon of the China Theater. Since that time he has served as chief of personnel of the Medical Department, and for the past four years has beeen deputy Surgeon General.

During his military career General Armstrong has taken an active interest in the affairs of civilian medicine and medical education. He has served as a member of the House of Delegates of the A.M.A., and is a liaison member of the executive council of the Association of American Medical Colleges.

Colonel Don G. Hilldrup, a native Hoosier, has been appointed medical director of the Red Cross Defense Blood Center, at Indianapolis. He will assume his duties on July 1. Colonel Hilldrup is a 1915 graduate of Indiana University School of Medicine.

Dr. E. **Vernon Hahn** of Indianapolis has been appointed a member of the Advisory Council of the Indiana Department of Civil Defense by Governor Schricker. Doctor Hahn is co-chairman of the Committee on Civil Defense of the Indianapolis Medical Society and chairman of the Medical Services Division of the Marion County Civil Defense organization.

PHILANTHROPIC PLAN TO AID MEDICAL SCHOOLS

A unique philanthropic organization to provide financial assistance for all the nation's hard-pressed medical schools was launched in New York City on May 16.

The undertaking has the sponsorship of industry, the medical profession, organized labor, agriculture, a group of university presidents and 12 scientific and educational foundations.

The establishment of the National Fund for Medical Education was announced at the annual meeting of the sponsoring group at the Biltmore by former President Herbert Hoover, the Honorary Chairman of the Fund, and S. Sloan Colt, Fund President and President of Bankers Trust Company, New York.

At the meeting it was also announced that the American Medical Education Foundation, founded last December by the American Medical Association in Cleveland, will funnel its contributions from doctors through the National Fund organization. The National Fund plans to make these and other grants available immediately to the nation's medical schools, many of which have large deficits.

In announcing the new Fund, Mr. Colt told the meeting its launching culminates two years of planning and organization. He further made known that initial support had come from a wide spectrum of the American community including contributions from the medical profession and such other groups as 18 leading life insurance companies and many industrial corporations. To date, these contributions provide the National Fund with starting resources of more than $1,000,000, toward a $5,000,000 goal for the first year.

Mr. Colt told the meeting that the chief objective of the National Fund is to seek voluntary contributions in order to relieve the acute problem faced by medical schools in endeavoring to maintain high academic standards in the face of crippling budgetary problems.

Mr. Colt said that the Fund trustees had set up appropriate machinery for distributing the money equitably among the nation's medical schools. In developing this machinery, the Trustees were guided by their Advisory Council, which includes university presidents, representatives of the American Medical Association, the Association of American Medical Colleges, and the medical directors of several leading philanthropic foundations.

The Fund, Mr. Colt explained, has as its objective to turn over about $5,000,000 this year to the four-year medical schools and the approved two-year schools in the United States. It is hoped that in future years this figure can be raised substantially as the base of support is broadened nationally.

"This sum will not completely solve the distressing financial problem of American medical education," Mr. Colt said, "but it represents an important voluntary effort to help relieve the acute problem of the medical schools."

The American Laryngological, Rhinological and Otological Society held its annual meeting in Atlantic City on May 8, when **Dr. Ralph J. McQuiston,** of Indianapolis, was elected a regional vice-president.

PUBLIC HEALTH CONFERENCE

Dr. F. R. N. Carter, South Bend city health officer, was elected vice-president of the Indiana Public Health Association at the fifth annual conference held in Indianapolis on May 1 and 2. If precedent is followed, he will be named president-elect in 1952.

Dr. J. B. Carr, an Indianapolis dentist, assumed the presidency of the association, having been president-elect in 1950-51. Dr. W. W. Patty of Bloomington, dean of the School of Health, Physical Education and Recreation, Indiana University, was elected president-elect. Miss Hester Beth Bland of Indianapolis and Dr. Cecilia Schuck of Lafayette were re-elected secretary and treasurer, respectively. New members of the board of directors are Mrs. Ruth Theis, Ray E. Smith, Clarence L. Taylor and Mrs. Meredith Nicholson, Jr., retiring president, all of Indianapolis.

Among resolutions adopted were:

1. Endorsement of the principles of state and federal aid for full-time health departments.

2. Recommendation that law enforcement officers redouble efforts to reduce traffic casualties.

3. Suggestion that state and local appropriating bodies increase compensation for trained and experienced public health personnel so they will not be lost to industry and to other states.

4. Recommendation that state and local public health departments institute programs of home accident prevention.

Physicians were active in the conference, Drs. L. E. Burney and Philip B. Reed of Indianapolis, Dr. Ernest R. Carlo of Fort Wayne, and Dr. William D. Province of Franklin, appearing on the program. Dr. Byron N. Lingeman of Crawfordsville was chairman of the Program Committee, Dr. Walter L. Portteus of Franklin was chairman of the Resolutions Committee, and Dr. Gerald F. Kempf of Indianapolis was co-chairman of the Nominating Committee.

Maurice Early, *Indianapolis Star* columnist, received the distinguished service award for outstanding contribution to public health at the conference dinner.

Membership in the association was announced as 709 at the closing session. More than 300 persons attended the conference.

INDIANA TUBERCULOSIS ASSOCIATION

At the fortieth annual meeting of the Indiana Tuberculosis Association, at Indianapolis, on April 23, 24 and 25, Dr. Roscoe L. Sensenich, of South Bend, was honored by being the recipient of the first Auerbach Memorial Award, for his achievement in promoting tuberculosis control in Indiana. The award, which is to be presented annually, is in memory of Murray A. Auerbach, who was executive secretary of the association for twenty-nine years.

Election of officers of the association resulted in the following: Harold D. Caylor, M.D., Bluffton, president; Lynn Stewart, Columbus, first vice-president; William D. Province, M.D., Franklin, second vice-president; C. J. McIntyre, M.D., Indianapolis, treasurer, and Warren S. Tucker, M.D., Indianapolis, assistant treasurer. Dr. Horace Wanninger, of Richmond, was elected president of the Indiana Trudeau Society; Dr. Joseph W. Strayer, of Lafayette, president-elect; Dr. J. V. Thompson, Indianapolis, vice-president; and Dr. C. J. McIntyre, Indianapolis, secretary-treasurer.

CONTEST FOR INDIANA PHYSICIANS

Clinicians using the allergy concept have been obtaining remissions in cases suffering from chronic disease symptoms. These clinical results have derived from the application of diagnostic techniques evolved by Dr. Arthur F. Coca and described fully in the third edition of his "Familial Nonreaginic Food Allergy."

To develop further interest in examining procedures designed to control the disease-entity, L. S. Green Associates, New York City, is offering two annual prizes for the best papers to be submitted covering diagnosis and treatment of cases in this newly defined category of allergy (idioblapsis). The allergens are pulse accelerating; the patients compile a pulse record; and the physicians identify the substances by interpretation of the record made under prescribed conditions.

Any physician is eligible to submit a report provided he has been in private practice at least five years and is a clinic assistant. To qualify the paper must embrace at least twenty different patients whose symptoms must include one outside the range of atopic allergy.

The first prize of $100 and second of $50 is being offered to practitioners in Indiana initially because our state is fortunate in having two clinicians versed in the technique in question; and with a third judge to be selected, they have offered to examine and make the L. S. Green Associates Award to the winning papers. These physicians are: Dr. Milo G. Meyer, Michigan City, and Dr. Alan Johnston, Plainfield.

For additional information write to L. S. Green Associates, Public Relations Division, 160 West 59th Street, New York 19.

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

At the annual meeting of the Indiana Academy of Ophthalmology and Otolaryngology, at the Indianapolis Athletic Club on May 2 and 3, the following officers were elected: president, Dr. E. L. Van Buskirk, Lafayette; president-elect, Dr. Myron S. Harding, Indianapolis; first vice-president, Dr. Edgar C. Davis, Muncie; secretary-treasurer, Dr. J. C. Travis, Indianapolis. Dr. Kenneth Craft, of Indianapolis, was elected editor of the academy's *Transactions*. South Bend was selected for the meeting next year, which will be held during the last week in April. Guest speakers on the program were Dr. Paul Holinger, of Chicago, and Dr. F. Bruce Fralick, of Ann Arbor.

INDIANA HEALTH OFFICERS MEETING

The Indiana Health Officers Association, meeting in Indianapolis May 2 in connection with the Indiana Public Health Association, adopted a resolution requesting the House of Delegates of the Indiana State Medical Association to establish a Section on Preventive Medicine and Public Health.

Another resolution called upon funds-appropriating bodies to increase salaries of public health departments.

Dr. Donald Harris, who resigned as Gary city health officer to enter health and welfare work at Frankfort, Germany, for the U. S. Department of State, resigned as secretary. Dr. Otto F. Lehmberg, health officer at Columbia City, was elected to succeed him. The next meeting of the association will be Sunday, October 28, which is the day preceding the opening of the annual meeting of the state medical association.

POSTGRADUATE COURSES

The Michael Reese Hospital Postgraduate School is offering a two-week course in "Diseases of the Endocrines—Physiology and Diagnostic Methods." This full-time intensive course will meet from July 9th to July 21st, 1951, and consists of a balanced program of basic information and clinical applications. For further information, address: Dr. Samuel Soskin, Dean, 29th St. & Ellis Ave., Chicago 16, Ill.

A full-time intensive course in "Hematologic Diagnosis," under the direction of Dr. Karl Singer, will be presented by the Michael Reese Hospital Postgraduate School from July 23rd to August 4th, 1951. This two-week course offers a review of the present status of hematology and instruction in actual reading of slides of normal and pathological specimens of peripheral blood and bone marrow. For further information, address: Dr. Samuel Soskin, Dean, 29th St. & Ellis Ave., Chicago 16, Ill.

MADISON COUNTY ESSAY CONTEST

Madison County Medical Society, in cooperation with the Association of American Physicians and Surgeons, conducted an essay contest among high school students on "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care." The first prize of $100 was awarded to Judith Mason, of Anderson; second prize, $30, to Rex Etchison, Frankton; third prize, $20, to Mary Butler, Anderson. The first three prize-winning essays are sent to the Chicago office of the AAPS, for entrance in the national contest.

Dr. Andrew C. Offutt, a native of New Castle, has been appointed Director of Communicable Disease Control by Dr. L. E. Burney, State Health Commissioner. Following graduation from Indiana University School of Medicine Doctor Offutt entered the army, where he had extensive experience in communicable disease control.

Dr. H. Paul Miller, of Fort Wayne was appointed Allen County Coroner, effective May 1. He was reelected to a second two-year term in November 1950, but was recalled into service with the U. S. Army Medical Corps in January. He was recently released from the service, in consideration of his extensive service in World War II.

Dr. Merle Bundy, who has been director of the Division of Tuberculosis Control at the Indiana State Board of Health, since 1947, will serve in a similar capacity with the Pittsburgh, Pennsylvania, City Health Department, effective June 18.

Dr. Gene S. Pierce, of Wheatland, has moved to New Albany, where he has opened an office for the general practice of medicine and surgery.

Dr. John Terveer, of Decatur, received orders to report June 3 for military services with the medical corps.

RESEARCH GRANTS

Among research contracts recently announced by the U. S. Atomic Energy Commission were the following for Purdue University:

Investigator	*Title*	*Duration*
Dr. W. W. Brandt	Metal Ion Chelate Complexes	June 30, 1952
Dr. T. Devries	A Study of Polarography in Non-aqueous Solvents	June 30, 1952
Dr. W. F. Edgell	Studies in Molecular Spectroscopy	Jan. 31, 1952
Dr. M. G. Mellon	Spectrophotometric Studies of Complex Ions	Jan. 31, 1952
Dr. W. H. Johnston	Gas Phase Exchange Reactions	Jan. 31, 1952

Dr. John Hartman, of Angola, has been recalled to active duty with the Army Medical Corps.

Following completion of his internship at Indianapolis General Hospital, **Dr. Robert Abel** has opened an office for the practice of medicine in Wakarusa.

Dr. F. M. Fellers, of South Bend, returned to active duty with the Air Force on May 1. He is a captain in the reserves, and served for twenty-two months in the Pacific theater in World War II.

Dr. Frederick H. Simmons, of Marion, has returned to private practice. He has been a member of the staff of the VA hospital in Marion.

Dr. Charles C. Crampton, of Delphi, who was chosen as Indiana's General Practitioner of the Year in 1949, received further honor recently, when he was presented with the Distinguished Alumni Award at the 77th anniversary of Founders Day at Purdue.

Dr. Gerald W. Gustafson, of Indianapolis, gave an obstetric manikin demonstration on the program of the Minnesota State Medical Association, at its annual session April 30 to May 2, in Rochester, Minnesota.

Dr. William C. Gallo, formerly with the Cold Spring VA Hospital in Indianapolis, is now radiologist at the VA Hospital at Margaretville, New York. He is a 1939 graduate of Johns Hopkins School of Medicine, and is a veteran of World War II.

Dr. Thomas Brown, of Delphi, was appointed city health officer for a four-year term. At the same time, **Dr. George Wagoner** was appointed to a two-year term on the city health board.

Dr. John Lloyd, of Bluffton, has moved to Louisburg, North Carolina, where he has opened an office for the practice of surgery. For the past two years he has been associated with the Caylor-Nickel Clinic.

Dr. J. E. McMeel, of South Bend, was elected president of the Northern Tri-State Postgraduate Medical Association at its annual meeting in Toledo, Ohio, in April. **Dr. L. P. Harshman**, of Fort Wayne, was elected secretary.

Indiana University News Notes

The Student Union, food service and housing building for the Medical Center campus, is nearer a reality with the excavation work going on in full swing. On the basis of state and federal grants approved previously, materials for the building and much of the equipment had been ordered prior to the sale of bonds, completing the financing of the $4,000,000 structure.

The eight-story building, including basement, will house kitchens, dining rooms and other food service facilities for Medical Center patients, staff and students, and in addition will serve patients and staff at the state's new LaRue D. Carter hospital and the staff of the State Board of Health. These facilities are being provided by a state appropriation and a grant of federal Hill-Burton funds.

The building represents a major addition to the campus and provides a solution to the pressing problems of food service and housing, of recreational facilities for the growing number of students, and will be an important factor in expansion of postgraduate education programs in the Medical, Dental, Nursing and auxiliary schools on the campus.

Dr. Herbert S. Gaskill, Professor of Psychiatry at the School of Medicine, has returned from a month's assignment in Japan as a consultant on psychiatry with the Army Medical Corps.

The 31st annual postgraduate Anatomical and Clinical Course in Otorhinolaryngology was held on the Medical Center campus April 2 to April 14 inclusive. Thirty-two ear, nose and throat specialists from 17 states, the District of Columbia and Canada were in attendance for the two-week series of lectures and laboratory demonstrations in charge of Dr. C. H. McCaskey and Dr. E. N. Kime. Assisting in the presentation of the course were Dr. J. L. Arbogast, Dr. Robert Heimberger, Dr. H. B. Shumacker, Jr., Dr. L. W. Freeman, Dr. D. N. Walcher, Dr. H. M. Trusler, Dr. J. J. Mahoney and the staff of the ENT and Anatomy departments of the Indiana University School of Medicine.

Approximately 750 alumni attended the fourth annual Alumni Day at Indiana University on May 9. The program in the morning consisted of sightseeing tours of the campus, upon which four new buildings have been constructed within recent months. Following a picnic lunch on the campus, the alumni heard an address by Major General George E. Armstrong '25, on "The Armed Services and the Physician," and remarks on "Looking to the Future," by Dean John D. Van Nuys. Candidates nominated for next year's officers, who will be voted on by mail ballot, are: Drs. Raymond C. Beeler, Indianapolis, and Dillon Geiger, Bloomington, president; Dr. J. Neill Garber, Indianapolis, vice-president; Dr. D. J. Caseley, Indianapolis, secretary; Dr. Marvin L. McClain, Scottsburg, treasurer; and Dr. Frank Forry, Indianapolis, historian.

Approximately 100 surgeons from Indiana, Ohio, Illinois, Michigan and Wisconsin were on the campus Monday, April 9, for a regional meeting of the International College of Surgeons. Dr. George J. Garceau, chairman of the department of Orthopedic Surgery, is regent of the District organization.

A large group of physicians and dentists from over the state met on Tuesday and Wednesday, April 3 and 4, at the Medical Center for the fourth annual Symposium on Malignant Disease sponsored by the School of Medicine, the School of Dentistry and the Indiana Cancer Society.

In conjunction with the two-day meeting the sixth in the series of Telephone Seminars was presented on the first evening of the meeting as a roundtable discussion of cancer with Dr. E. A. Lawrence, a member of the Medical School faculty, as moderator. Other speakers on the panel, who also were guest speakers for the Symposium, included: Dr. Warren H. Cole, University of Illinois; Dr. John J. Bittner, University of Minnesota; Dr. John D. Trawick, Jr., University of Louisville; Dr. Juan del Regato, director, Penrose Cancer Hospital; and Dr. Edward B. Smith, Washington University.

A.M.A. WASHINGTON OFFICE NEWS

Better Protection Against Radiation Sickness Forecast by AEC. *Dr. Shields Warren,* head of Atomic Energy Commission's Division of Biology and Medicine, has informed a House Appropriations subcommittee that the time is not far off when protection against radiation sickness will permit "twice the single exposure dose now believed to be lethal." Research workers have fully demonstrated the usefullness of antibiotics in tiding irradiated animals over the period of reduced resistance to infection. Tests also have disclosed that animals whose tissues are deficient in oxygen have a better chance of surviving lethal dosages of radiation than normal animals. Other points in his testimony were (1) survival chances are increased in animals by the sulfur-containing amino acid (cysteine) and (2) by shielding the spleen of irradiated animals the normal lethal dose may be doubled and the blood-forming function of bone marrow quickly restored.

House Appropriations Committee Approves $75,000,000 for Hospitals. In recommending *$1,793,226,461* for Federal Security Agency for next fiscal year, the House Appropriations Committee approved an appropriation of *$75,000,000* for continuation of the *Hill-Burton* hospital construction program. In taking the action, the committee observed that in a war emergency "we would need far more hospital facilities than we now have." Their report also noted growing materials shortages and "limited availability of trained hospital personnel."

The committee was critical of FSA for having set up units under an assistant administrator for defense activities *"when FSA is not a defense agency."* The committee observed: "Why an assistant administrator for defense activities with a number of defense-titled units appended to him is needed in an agency like Federal Security is not apparent to the committee." One of these units is the Division of Civilian Health Requirements.

FSA's appropriation was cut about 7 percent below its budget estimate. Cuts were spread through various parts of the agency, including Public Health Service.

Senate Group Urges More Doctors, Nurses at Training Center Hospitals. Senate Preparedness subcommittee, reporting on inspection of 16 training centers and camps, recommends that "immediate steps" be taken to supply training center hospitals with additional medical personnel. The 10,000-word report issued by Chairman Lyndon Johnson (D.-Tex.) also called on examining officials at induction centers to weed out mentally or physically unfit recruits before they can be sent on to indoctrination centers.

The report said medical care at all indoctrination centers is *"adequate, prompt and considerate,"* although there is a shortage of doctors and nurses at most installations. "Available medical personnel are overworked, in some instances seriously," the report noted. It added that medical personnel shortage is complicated by "widespread lack of adequate hospital facilities" on some installations during periods when illness rate is above normal. The subcommittee did not specify what remedial steps should be taken.

Investigators found that generally all hospital facilities are maintained in excellent condition and attention to patients seems satisfactory. And they found no complaints from patients about their treatment. Respiratory infections were found to be the most common illness among trainees.

Conferees Eliminate Plan for Deferment of 75,000 Students. House-Senate conferees on the *draft bill* (S. 1) have agreed to leave authority for deferment of students in the hands of local draft boards, which may (but are not required to) take into consideration class standing and results of nationwide tests. Deferment totals would fluctuate with military manpower requirements. The conference committee also agreed to add *optometrists, dentists* and *osteopaths* to the list of persons who may be deferred by local boards, if they are found to be essential. However, *chiropractors,* whose deferment eligibility was recommended by the House, *are not included.* The conference also agreed that organized reservists and non-veteran inactive reserves may be kept on active duty for not to exceed 24 months, the same service period set for draftees. Draftees will be liable for a total of eight years' service; divided between active duty or UMT and reserve duty, when and if UMT is put in operation. (For the present, this will mean 24 months active duty and six years in the reserves.) The conferees left intact the doctor-draft law (P. L. 779, 81st Congress), amending it only to extend active duty from 21 to 24 months. The clause providing deferment of premedical students in numbers equal to present enrollment in such courses is retained.

Commissions Still Available to Doctors Facing Draft. Selective Service assures us it will continue to help physicians get reserve commissions before the time comes for actual drafting. After Defense Department called on Selective Service to draft 1,202 Priority I physicians this summer, Selective Service officials made these points plain to us:

1. Men selected for drafting *will be notified in time to apply for reserve commissions.* Local Selective Service boards will have Defense Department Form 390 for those who previously indicated they were not interested in a reserve commission but who might now want to apply. Boards also will expedite processing of men who previously indicated they wanted commissions.

2. Within the priority, age will determine the order of call-up, with the youngest going first; the same system applies to reserve officers.

3. Priority I physicians classified 1-A may apply for a reserve commission, thus avoiding induction by Selective Service and assuring an extra $100 monthly pay, *but this will not mean a delay in going on active duty.* Either as reserves or draftees, 717 Priority I physicians will enter Army or Air Force in July, another 333 in August and 152 in September.

4. Selective Service plans to allot state quotas based on the proportion of Priority I men in the state to the national total. However, as the number of reserves commissioned increases, the number to be drafted will decrease proportionately, both nationally and by state.

The call for 922 physicians which Defense Department made on Selective Service last October 10 was filled by reserves, not draftees.

The latest mandatory call was more or less expected: Defense officials have complained in recent months that Priority I men were reluctant to volunteer. They were particularly concerned about men who had *indicated they would join the reserves* at the time of registration *but subsequently have done nothing about getting a commission.* Under the doctor-draft law the supply of men in Priority I must be exhausted before those from other categories can be drafted and Defense Department has adopted this policy with reserves. The call for 1,202 physicians will just about exhaust the supply of Priority I doctors, leaving the way open for call of Priority II men.

State Civil Defense Directors Urge Funds for Medical Stockpiling. State Civil Defense directors, meeting on eve of first course by Federal Civil Defense Staff College, called on Congress to give top priority for $70,000,000 *for medical supply stockpiling.* This sum was cut from the CDA's supplemental budget by the House and the bill is now before the Senate.

The directors said they placed the highest priority on prompt and effective treatment of injured following an atomic attack. Their resolution added: "Official statements by authoritative members of the medical supply industry and by qualified officials of the federal government have established the fact that *existing reserves of medical supplies are entirely inadequate* to meet even the minimum emergency requirements."

Report on Reserves Presented to House Committee. The long-awaited Defense Department plan for reorganizing all military reserves has been presented to the House Armed Service Committee It was drawn up in response to a demand several months ago from Chairman Carl Vinson for a program that would *turn the "paper reserve" into a real organization,* prepared to train the hundreds of thousands of men who will enter it under the new manpower bill.

Part of the new plan would be put into effect by regulation, the rest with passage of legislation which Defense Department now is drafting. It is designed to revise and revitalize all phases of the reserve organization—training, promotions, benefits, priority of call. One of the major innovations would split the reserves into three new classifications, (a) *ready reserve* units and individuals subject to call at any time by the President, (b) *standby reserves* and groups to be called only in time of war or an emergency declared by Congress and (c) *retired reserves* who could be activated only in time of national emergency.

At the same time Defense Department announced that Army and Marines will start releasing men called involuntarily from the *inactive reserve,* officers as well as enlisted men, this summer. Navy and Air Force at the same time will be releasing *inactive* reserve *enlisted men,* but have made no announcement about officers or enlisted men from the active reserve. Nothing was said of the National Guard. Present members of the reserve would be placed in the appropriate new classification.

VA Explains Provisions of New Insurance Law. VA explanation of $10,000 free insurance law (P. L. 23): "On or after June 27, 1950, any person in active military or naval service . . . including Public Health Service . . . shall be automatically covered against death in active service for $10,000, less any NSLI or USGLI (World War I) in force at time of death. The amount of any NSLI or USGLI in force at death, plus the indemnity, may not exceed $10,000 . . . Protection continues for 120 days after separation from service . . . Persons in active service may surrender their NSLI or USGLI permanent policies in force for a year or more for the cash surrender value. Then, within 120 days after separation from service, they may apply without a physical examination to the VA in writing for permanent type insurance on the same plan not in excess of the amount surrendered. Or they may reinstate the surrendered insurance by payment of the required reserve and the current premium."

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

April 29, 1951

The Council of the Indiana State Medical Association convened for its spring meeting at 10:10 a.m., Sunday, April 29, 1951, in the Columbia Club, with Dr. W. U. Kennedy, chairman, presiding.

Roll call showed the following present:

Councilors:

First District	Herman T. Combs, Evansville
Second District	William C. Reed, Bloomington
	Sam I. Rotman, Jasonville, alternate
Third District	William H. Garner, New Albany
Fourth District	Not represented
Fifth District	V. Earle Wiseman, Greencastle alternate
Sixth District	W. U. Kennedy, New Castle
Seventh District	Roy A. Geider, Indianapolis
	Don E. Wood, Indianapolis, alternate, and co-chairman, Legislative Committee
Eighth District	E. H. Clauser, Muncie
	T. R. Hayes, Muncie, alternate
Ninth District	Wemple Dodds, Crawfordsville
	Harry E. Klepinger, Lafayette alternate
Tenth District	William H. Howard, Hammond
	J. Robert Doty, Gary, alternate
Eleventh District	Elton R. Clarke, Kokomo
	R. W. Lavengood, Marion alternate
Twelfth District	M. B. Catlett, Fort Wayne
Thirteenth District	Kenneth L. Olson, South Bend
	G. O. Larson, LaPorte alternate

Officers:

Alfred Ellison, South Bend, president.
J. William Wright, Indianapolis, president-elect.
Roy V. Myers, Indianapolis, treasurer.
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL.
Walter L. Portteus, Franklin, chairman, Executive Committee.
C. J. Clark, Indianapolis, member, Executive Committee.
Albert Stump, Indianapolis, attorney.
Ray E. Smith, Indianapolis, executive secretary.
James A. Waggener, Franklin, field secretary.

Guests:

J. Neill Garber, Indianapolis, chairman, Committee on Convention Arrangements.

John E. Owen, Indianapolis, chairman, Committee on Military Manpower.

Cleon A. Nafe, Indianapolis, chairman, Indiana A.M.A. Campaign Coordinating Committee, and alternate delegate to the American Medical Association.

On motion of Drs. Reed and Combs, the minutes of the midwinter meeting of the Council, held at Indianapolis on January 14, 1951, were approved as printed in the March, 1951, issue of THE JOURNAL.

REPORTS OF COUNCILORS

The councilors announced the dates and places of their spring district meetings and invited the officers of the association to attend.

Doctor Ellison called attention to the fact that this year two district meetings are scheduled on each of three dates, making it impossible for the state officers to attend all district meetings. He suggested that the district societies in the southern half of the state might hold their meetings in April and those in the northern part of the state might meet in May, thereby avoiding some of these conflicts. Each councilor was asked to notify the headquarters office if his district society by-laws make it mandatory that the society meet on a set date.

Several of the councilors spoke of increased attendance and interest in society meetings due to the popularity of the telephone seminars sponsored by the Committee on Medical Education and Hospitals.

Dr. E. R. Clarke stated that "Organizational work in formation of disaster committees and practical plans to put in effect an emergency set-up are still lagging for the most part. This work should be pushed vigorously."

REPORT OF SPECIAL COMMITTEE ON DISABILITY INSURANCE

Doctor Catlett, chairman, reported that his committee had held several meetings and had collected a great deal of information. About twelve companies writing noncancellable disability insurance submitted their policies to the committee for study. None of these policies complied 100 percent with the standards set up by the committee. This was to be expected, however, since the standards adopted were very high and were publicized to the insurance companies in the hope that the companies, after studying them actuarily, might find it would be good business to write a policy which would conform to these standards, or if not, it would at least increase the value of their policies to the physicians.

Doctor Catlett said he had received a letter from the executive secretary in which the Executive Committee expressed the feeling that the association was creating a great deal of antagonism among insurance companies and the public over the state, and receiving a lot of adverse criticism from insurance people, by approving certain disability insurance policies, and suggested that the Council reconsider this whole matter.

Doctor Olson, a member of the Disability Insurance Committee, said that the committee finally decided to approve all noncancellable, guaranteed, renewable policies, as it seemed that that

was the policy most acceptable, and to publish in THE JOURNAL the information it had gathered, as an educational thing as to what to look for in buying insurance.

Following discussion by Drs. Hayes and Geider, on motion of Drs. Catlett and Geider, the Special Committee on Disability Insurance was authorized to write, for publication in THE JOURNAL, a resumé of the information it had gathered. The committee is to be continued, but it is to remain dormant until it is called upon again.

REPORTS OF OFFICERS

Dr. Alfred Ellison, president, 1951: "The affairs of the society, we feel, are going along in an efficient manner. We were very fortunate in having some outstanding committeemen take the posts the beginning of this year, and they are doing a great job. Some committees are outstanding in their efforts. I suppose you are aware of the fact that May is a pretty heavy month in organized medicine. All of the districts except two have their district meetings this month. In addition to that, the Rural Health Committee is sponsoring five meetings in different sections of the state, so it makes an extremely heavy program.

"I might say to you that I am personally happy to see the action taken just now on this health and accident insurance matter. I think it is the wisest course that we could follow. I think that our experience with the life insurance business and with this business should give us an inkling of the fact that we ought to stick to medicine as close as we can and not get too far in to the insurance business, because in both cases it has served unfortunately to bring ill feeling, misunderstanding, and misjudgment of our intentions, and it hasn't resulted in very favorable public relations."

Dr. Frank B. Ramsey, editor of THE JOURNAL: "THE JOURNAL has been running along very well, financially and otherwise. In June we plan to publish the medical civil defense plan of the Indianapolis Medical Society, and I may be prejudiced, since I am a member of the committee that has been working on it, but I believe it is going to make a nice number. I believe it will be the first time, unless one appears between now and then, that a medical plan that has been worked out in detail has been published, and I think we may get the reputation of being the first state to publish a well-worked-out plan. We have made arrangements for reprints of all of it.

"The July issue of THE JOURNAL this year will be the regular year-book number, and I would like to ask if any of you have suggestions as to subjects of a medical-legal nature, or of reference type, that could be prepared for the July number. We would like to have those suggestions. I would say this report on disability insurance, if it could be drawn up within the next two or three weeks, would make a good article for the July number—something to refer to. We have published information on insurance subjects in the year book before and I believe it is a good thing to have. I have asked Doctor Burney to make any suggestions he has for anything the State Board of Health would like to put in, and Mr. Stump has a couple of subjects on his mind."

UNFINISHED BUSINESS

1. **Report of Special Committee on Income Pension Plan.** *Dr. E. R. Clarke*, chairman, read the following letter concerning the reception of the Independence Plan which he had received from the Jefferson National Life Insurance Company:

> "I wish to report that the Independence Plan of the Indiana State Medical Association is being very well accepted by the members that have been contacted to this date. Especially have the young men of the medical profession taken advantage of the plan. In almost all localities we have met with fine cooperation. The most serious problem is being able to make appointments with the practicing doctors as they are very busy men. However, we feel that in a period of a year we shall have placed a great number of the members in this wonderful Pension Plan. We feel certain that most of the eligible members will become a part of the plan within the first two years. Many will be able to fit this plan into their retirement program within that time.
>
> "We wish to thank the Indiana State Medical Association for the very splendid cooperation that they have given us in making this program a success."

On motion of Drs. Howard and Combs, Doctor Clarke's reported was approved.

2. **Indiana A.M.A. Campaign Coordinating Committee.** *Doctor Nafe*, chairman: "I feel that this committee should have some guidance from the Council as to what it wishes done this year. We had thought our activities should not be as great this year as they were last, especially in the field of newspaper advertising, carrying statements from the Indiana State Medical Association. We plan this year to carry two or maybe three such ads; the first one we contemplate is a rather large spread based on the exchange of telegrams between Mr. Ewing and Doctor Henderson relative to the controversy in The A.M.A. Journal in which they quote from a report sent out by the Federal Security Administration. . . .

"The Campaign Committee has felt very much that most of our attention this year should be towards a constructive program. Now, we have gone over the ideas we would like to put out—what the doctors are doing, what they are trying to do, what they want to do, to make medical care satisfactory to the people of Indiana. Our constructive program includes (1) advising everyone that they should have a family doctor, why it is advisable that they have a family doctor, and if they are unable to contact their doctor, that most medical societies are setting up emergency service so that medical service is available at all times to all of the people of Indiana; (2) publishing well-written statements about medical

costs—that we feel it is the obligation of people to talk over with the doctor the contemplated expenses of illness . . . This year the major problem we have is to get the people on our side by a very carefully, well-rounded public relations program to convince them that the doctors are trying to do a job. That was the idea of this second, rather large display which we expect to run in all newspapers. That would take about $30,000. If we had a third one, that would take some more money. We will spend what you want us to; we don't want to spend any more.

"We of course are going ahead in getting resolutions. Indiana now has 2,220, according to the last count. The next state to us has 900. The Woman's Auxiliary and many of you doctors should be credited with that accomplishment.

"We contemplate that next year we will have a job to do again.

"It is a pretty hard problem to get these ads worded properly to suit everybody. It's a pretty hard job to say the right thing to catch the fancy of the people who read them."

1951 ANNUAL SESSION AT INDIANAPOLIS

Doctor Garber, chairman of the Committee on Convention Arrangements, announced that he would present a detailed report and definite estimate on entertainment costs to the Council at the July meeting. Action on the convention budget was therefore postponed until that time.

MEMBERSHIP PROBLEMS

1. **Age at which members are eligible to senior membership.** On motion of Drs. Reed and Catlett, the Council rescinded its previous action in which it had interpreted the Constitution to mean that a member is eligible to senior classification *the year after* he reaches the age of seventy-five, and ruled that a member is entitled to senior membership *the year in which he reaches the age of seventy-five.*

2. **A.M.A. membership dues.** Following discussion by Doctor Nafe, on motion of Drs. Catlett, Geider and Howard, the Council voted that the delegates and alternates to the American Medical Association meeting in June be instructed as follows:

(1) To vote for the abolishment of the Fellowship classification in the A.M.A. and the $5.00 Fellowship fee.

(2) To support a resolution rescinding the present rule which makes it mandatory that a delinquent member pay one year's delinquent dues before he can be reinstated.

LEGISLATIVE MATTERS

Doctor Wood, co-chairman of the Committee on Public Policy and Legislation, discussed the following legislative problems: (1) Relation of the medical profession to the employer and to labor; (2) Health units, state and county; (3) Chiropractic situation, and (4), The national situation. He asked for the cooperation and interest of all members of the association during 1952.

NEW BUSINESS

1. **Matters referred to Council by Executive Committee:**

a. **Request for funds to improve nursing in Indiana.** *Doctor Portteus, chairman of the Executive Committee,* explained that the Indiana State Nurses' Association is attempting to carry out two projects in the state of Indiana. One is the so-called upgrading course in which there will be an effort made to improve the nursing education requirements both of graduates and nursing aids, and then a research program, which will cost a total of $25,000. "I will read you this summary which is very brief:

"'The total estimated cost for the two projects for improvement of nursing in Indiana is:

The Upgrading Course	$10,000
Dr. Bixler's research	15,000

"'Health is one of the major foundations of sound national economy and well being; nursing is one of the important services by which optimum health can be attained and maintained. Nursing today, in the nation and in Indiana, has many lacks that need to be studied; nevertheless, the situation is neither bleak nor hopeless. Nurses, here in the state, have indicated tremendous potential for growth and development in good service and, besides our own interest in achieving these, have the interest of both lay and professional groups, nursing and non-nursing groups. The Committee, representing nurses in the state, believes that the two projects outlined above represent first sound steps toward better nursing in the state; it believes that it is justified in presenting its needs and in soliciting both moral and financial support.'

"The Executive Committee feels that this is a good project and worthy of our support, and we recommend to the Council that it authorize the appropriation of $1,000 to be applied to this study of nursing care in the state of Indiana, to be used as the Nurses' Association sees fit on these two projects."

Mr. Smith explained that the State Nurses' Association, the State Nurses' Registration Board, and the League for Nursing Education have joined in the project which has two objectives:

(1) To make a survey of nursing education facilities in the state, and as a result, better plan for nursing services in the future;

(2) To establish a course of education for practical nurses, the idea being to make them more acceptable and more serviceable in the care of patients. These courses will be given in various parts of the state and will enable these nurses to bring up their educational standards.

"The State Nurses' Association is putting $5,000 of its own money in this project; the nurses are trying to help themselves; they are trying to find out if their education is proper. They are

very definitely, I think, trying to do everything they can to provide more nurses."

Doctor Ellison: "I think we should realize that the nursing profession is in a very remarkable state of transition right now. Those of us who work in hospitals where floors have had to be closed because of the lack of nurses appreciate the acuteness of this situation. After all, we not only need hospital beds, but we have at times needed nurses to man the beds that we have, and it is well known to all of you, I am sure, that the patients are receiving a dangerously low standard of nursing care in a great many places. So the nursing problem has been an acute one, one that we as doctors of course are intensely interested in. Now, the so-called registered nurses, by registered nurses is meant the girl who goes for three years through the ordinary three-year course of education which the hospitals over the state give—their organization has at long last agreed with the thinking that has been expressed here in the Council on previous occasions, if you recall, that to do ordinary, routine, bedside nursing care does not require a girl of average intelligence three years to learn. There are a great many factors as to why girls don't go into nursing, and one of the outstanding reasons, they feel, is that the three-year period of time required discourages a considerable number. They think that if there can be established a one-year course,—six months, incidentally, of which would be spent in the classroom, and six months in the hospital—getting a practical education, they could turn out a very acceptable quality of practical nurse. Now, as I say, these official nursing organizations have at last agreed to do that, and in fact are wholeheartedly in accord with it and are taking the ball and are running with it.

"The officials of all of the nursing organizations met at French Lick during the annual convention of the Indiana State Nurses' Association, and they very enthusiastically celebrated recognition by the state legislature of practical nurses. As you probably know, our state legislature at this last session officially set up a board of examination for practical nurses, recognizing them, and setting up their status. They provided for a grandfather clause to take care of those women who have called themselves practical nurses in the past, providing that these women, if they have practiced practical nursing two out of the last five years, are eligible to take the examination—the same examination that a girl would take who spends one year in an approved school, then could be licensed and officially recognized as a practical nurse.

"Now, in doing this I think that everybody concerned with the matter is very positive in their attitude that we should not by any stretch of the imagination intend to lower the standard of nursing care or the standard of nursing education. We would then have three classes of nurses. You would have the practical nurse who would have this one year's course of education and whose duties would be limited to the routine care of patients at the bedside. You would have the so-called registered nurse who has spent three years in the hospital in the ordinary course of instruction that we now think of and those girls would be, of course, the ones who would supervise the floors and take charge of the administration of medicines that have a hazard to them and take part likewise in some of the courses of instruction; and then we would have the third class, the girl who has the ambition to go on to college and get her fourth year in college and get a degree. Those women, of course, are needed in research in nursing and they are needed in the schools of nursing, to administer those schools and to do the instructing. It is their hope and ambition that this study we are discussing today will help to iron out these things and point to other deficiencies and dangers that they might run into and try to avoid them. I think that if anybody should be interested in this problem, we should be.

"The growth of this trend toward accepting the practical nurse as a reality is evidenced by the fact that Indiana is the twenty-eighth state to recognize officially and license the practical nurse, and there are some eighty-five schools now in America that are set up officially and are approved to teach practical nursing. We have only one in Indiana so far, one here in Indianapolis. Incidentally, almost all of those schools are operated by the school systems instead of by the hospitals, and apparently the main reason for that is because of the economic support the school systems can give to them. It is obvious that these schools have to have an alliance with the hospitals in their respective communities."

On motion of Drs. Reed and Catlett, the Council approved appropriation of $1,000 to this project, the money to be paid from the funds of the Indiana A.M.A. Campaign Coordinating Committee.

b. **Participation in American Medical Education Foundation.** Doctor Portteus read the following letter from Dr. Donald G. Anderson, secretary-treasurer of the American Medical Education Foundation:

"I was sorry to learn from your letter of March 26 that the Executive Committee of the Indiana State Medical Association has decided against setting up a committee for soliciting contributions to the American Medical Education Foundation.

"While I realize that setting up such a committee will add to the work of the officers of the society, I do hope that they will reconsider this decision. We are very much afraid that unless active committees are formed at the state and local levels to spur physicians' interest in the Foundation, contributions will not amount to much. To date, we have had only two contributions from Indiana totalling $11.00.

"We have undertaken a big job on behalf of the medical profession and I hope that you will give us all the help that you possibly can."

Doctor Portteus said the Executive Committee felt that inasmuch as this project is sponsored by

the American Medical Association, it should be referred to the Council for final action.

During discussion by Drs. Combs, Ellison, Clarke, Dodds, Reed and Clauser, it was suggested that some of the Indiana A.M.A. Campaign Coordinating Committee's funds be diverted to the American Medical Education Foundation. Doctor Nafe, chairman of the coordinating committee, said he favored the allotment of certain funds to the American Medical Education Foundation but if these funds are to be taken from the coordinating committee's budget, the amount would depend upon how extensive a program the Council wished his committee to develop. Doctor Ellison said, "We should at least think about giving five or ten thousand dollars of our money to this fund."

On motion of Drs. Catlett and Clarke, the Council voted to postpone action on this question until its next meeting.

c. **Resolution adopted by the Congress of Delegates of the American Academy of General Practice, San Francisco, March 19, 1951.** Doctor Portteus read the resolution:

WHEREAS, The Congress of Delegates of the American Academy of General Practice in 1949 went on record as urging the American Medical Association, as the governing body of organized medicine, to take over the function of standardizing hospitals previously handled by the American College of Surgeons; and

WHEREAS, in 1950, without consultation with the American Medical Association, the American College of Surgeons entered into negotiations to turn over this function in its entirety to the American Hospital Association, which is a layman's organization not bound by the oath and tradition of American medicine; and

WHEREAS, this move was temporarily thwarted by the activities of our organization; and

WHEREAS, at the interim session of the American Medical Association, this subject did not reach the floor of the House of Delegates; and

WHEREAS, rumors of a compromise agreement with the American Hospital Association still persist; and

WHEREAS, the effecting of a compromise agreement dividing the responsibilities between the medical profession and the American Hospital Association would be a deadly blow to the medical control of hospitals; and

WHEREAS, this organization has already taken its stand on this subject;

Be It Resolved, that the Congress of Delegates of the American Academy of General Practice reaffirms its stand that the American Medical Association, the organization representative of all doctors, assume full responsibility for the standardization of professional practice in hospitals and that its committee for this purpose include specialists, general practitioners and medical educators; and

Be It Further Resolved, that in the short time that elapses before the next session of the House of Delegates of the American Association an all-out effort be made in all states to bring this matter for discussion to the floors of the House of Delegates of the various state medical associations, and that a specific effort be made to explain this in detail to the House of Delegates of the American Medical Association; and

Be It Further Resolved, that the executive secretary of the American Academy of General Practice be directed to prepare a resumé of the problem to date and a model resolution suitable for presentation to the respective state houses of delegates, and that such resolution be provided to each state academy chapter with instructions to implement suitable presentation.

Adoption of this resolution in affirmation was moved and seconded, with the further provision that the resolution be transmitted to the Executive Committee of the Indiana State Medical Association, in lieu of the House of Delegates of that association, with the request that that committee acquaint the delegates to the American Medical Association from Indiana with this resolution and if agreeable, urge these delegates to support this resolution and work for it.

Doctor Portteus: "The Executive Committee supported this view, that at the interim meeting of the House of Delegates of the A.M.A. at Cleveland last December the Board of Trustees reported that these discussions were continuing concerning this problem of standardization of hospitals and announced that they revolved about a proposal for the creation of a committee of twenty-four to supervise and direct the program, eight members of which would be from the A.M.A., eight from the American Hospital Association, four from the American College of Surgeons, and four from the American College of Physicians. The Executive Committee last night voted to support that aspect of it, in other words, to go along with the feeling of the Board of Trustees of the A.M.A. . . . The American Hospital Association has taken over the function, as I understand it, at this moment, and there is still some question as to whether or not they will relinquish their hold upon this thing, to set up a committee of this sort."

On motion of Drs. Catlett and Olsen, the Council voted approval of the action of the American Medical Association, and the Indiana A.M.A. delegates are to be instructed to support the Board of Trustees of the American Medical Association when this matter comes up before the A.M.A. House of Delegates in June.

2. **Committee on Military Manpower.** Doctor Owen, chairman, reported as follows:

"Recent newspaper publicity of the Army requisition for 1,202 doctors to be called up during the late summer means that the processing of registrants under P.L. 779 is practically complete and the only thing that will avoid the activation of the draft will be the volunteering of the registrants.

"Again it should be emphasized that the Advisory Committees and the Military Manpower Committees have no voice in the physical selection of registrants. This is done on the basis of Army classification. Current records show that about 20 percent of Priority I are disqualified for physical reasons in this state. Deferral has been granted to 15 percent for reasons of essentiality to the health and welfare of the community. This group includes residents and interns, as well as those who are the only physician in their community. Deferment is for a limited period only and is subject to review and reclassification at its termination. A permanent deferment must have the recommendation of local and state committees and



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Feinberg, S. M.: Asthma—Present Status of Therapy, Chicago M. Soc. Bull. 51:1062 (June 18) 1949.

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be submitted to the National Advisory Committee for action.

"So far in this state the number of volunteers has more than kept pace with the Army requisitions for officers though there are a number who have not indicated their acceptance of the inevitable.

"The number of physicians entering the service so far have not created too serious a shortage. If the present situation remains constant there will be doctors returning to the state before the shortage becomes serious.

"Priority II registrants are fewer in number than Priority I and the number disqualified for physical reasons and deferred as essential run parallel to Priority I.

"Classification of reserve officers in their relative priority and a determination of their local essentiality is another responsibility of the committee. This problem is being worked on now.

"Several meetings of the state committee have been held and a majority attendance and free discussion of the various problems have been carried on. The division of the state into districts was done to promote local autonomy.

"Cooperation of the local committees has varied, though the few complaints reaching the state committee lead us to believe that so far the setup is working as it is intended. One fact should not be forgotten—the committee's action is advisory.

"A part-time clerk has been furnished from the national advisory committee appropriation and it is hoped that we will be able to furnish rather prompt replies to any inquiries sent us.

"A file of all registered physicians of the state is under process. This will be supplemented by direct inquiry when information on specific problems is needed."

3. **Telephone seminars.** On motion of Drs. Elton R. Clarke and Reed, the Council congratulated the Committee on Medical Education and Hospitals and those responsible for the telephone postgraduate seminars for having done a unique piece of work and approved continuation of the plan for another year.

4. **The American Way.** At the request of the chairman of the Council, Doctor Combs agreed to prepare a paper on the organization, methods and techniques of The American Way, for presentation to the Council at the July meeting.

5. **Screening of nominations for General Practitioner Award.** By consent, the Council approved the appointment by the president of a screening committee to review in advance of the House of Delegates' meeting the nominations for the general practitioner of the year. This committee is to select the three most deserving candidates and give the papers to the chairman of the Council for presentation to the House of Delegates.

6. **Grant County Medical Society resolution.** Doctor Lavengood presented the following resolution, the purpose of which he said was to start an educational program, and asked for the support and advice of the members of the Council:

WHEREAS, the American Hospital Association has prescribed certain methods which, if reasonably followed, are generally believed to be conducive to the successful operation of public hospitals; but,

WHEREAS, said prescribed methods, like all methods, rules or regulations, are subject to reasonable construction and logical adaptation depending on the ramifications and contingencies which constantly arise in hospital management and operation; and,

WHEREAS, certain individual hospital administrators purportedly conducting hospital operations pursuant to the methods and recommendations of the American Hospital Association have deliberately failed to recognize the need for the construction of said methods and recommendations, but instead, deliberately have resorted to dictatorial mandates and stringent regimentation in an effort to execute the methods and recommendations of the American Hospital Association without regard whatsoever to human frailties and human feelings, having even gone to the extent of rendering lay opinions on medical problems, and asserting the superiority of such lay opinions over the opinions of established, experienced medical practitioners, as a result of which, internal strife and friction have developed between said lay administrators and various professional groups with which they come in contact; and,

WHEREAS, said strife and friction in many cases have spread to the extent that factions have been ereacted within certain of said professional groups which have proximately resulted in the fostering of hatred and hostility between the members thereof;

Now, Therefore, Be It Resolved, that the undersigned members of the Grant County Medical Society hereby utter written protest to the American Medical Association and the Indiana State Medical Association deploring and condemning the intentional or unintentional use by any hospital administrator or other person concerned of dictatorial, illogical or unreasonable tactics in executing the methods and recommendations sponsored by the American Hospital Association.

Be It Further Resolved, that the undersigned hereby protest against any and all type of conduct by any and all persons which Communistically fails to make allowances for human frailties and feelings and which fosters or which tends to breed discontent, hatred or prejudice within any profession or group of professions.

All of which was resolved, in open session, by the members of the Grant County Medical Society at Marion, Indiana, this 26th day of April, 1951.

GRANT COUNTY MEDICAL SOCIETY.
Russell W. Lavengood, M.D., Secretary.

This resolution was approved and adopted by the Miami County Medical Society at its meeting April 27, 1951.

C. R. Herd, M.D., Secretary.

The Council referred this matter to the State Board of Health Hospital Regulating and Licensing Council, of which Doctor Clauser is chairman.

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RECOMMENDED USAGE: Recommended daily limit for adults, 12 tablets or about 1½ teaspoonfuls of solution. Since the tablets contain sodium bicarbonate as a disintegrator, somewhat lower sodium diets are possible with the sodium solution than with the tablets. Sodium content per tablet is 21.64 mg., while an equivalent amount of sodium solution contains 14.25 mg.

Patients on strict low-salt diets, however, should use the calcium solution. The calcium form has a lower bitter taste threshold, noticeable in some foods when the proportion reaches 0.5 percent, compared to about 0.8 percent for the sodium form. Both forms are equally good in ordinary use.

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7. **Summer meeting of Council.** It was taken by consent that the next meeting of the Council should be held on Sunday, July 15, 1951.

There being no further business, the meeting was adjourned.

EXECUTIVE COMMITTEE

April 28, 1951.

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; Alfred Ellison, M.D.; J. William Wright, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guests: Lester D. Bibler, M.D., member of Committee on Veterans Affairs and Rehabilitation

Frank M. Hall, M.D.) State
Maurice Hunt, Administrator) Department
Miss Ethel Harrison, Director, Division of Public Assistance) Public Welfare

Membership Report

Number of members April 26, 1951	3,307*
Number of members April 26, 1950	3,405
Loss over last year	98
Number of members December 31, 1950	3,686

*Includes 44 in military service (gratis)

111—$10.00 members (residents and interns)
173 senior members
26 members, dues remitted by Council

Number who have paid 1951 AMA dues	2,622
Number who paid 1950 AMA dues	2,786

1951 Annual Session, Indianapolis, October 29, 30 and 31, 1951

(1) On motion of Drs. Clark and Wright the committee voted to invite the 1951-1952 president-elect of the American Medical Association to attend the annual dinner on the night of October 31.

Statements of receipts and expenditures were approved.

Legislative Matters

Local

Dr. Hall, Mr. Hunt and Miss Harrison presented statistics on cost of the medical care program of the Indiana Department of Public Welfare. The committee recommended that the amount paid to physicians be divorced from other so-called medical care expenses when information is made public.

Organization Matters

Indiana Foundation for Health. The chairman of the Committee on Rural Health is to meet with the Executive Committee at its next meeting to discuss the proposed Indiana Foundation for Health, on motion of Drs. Wright and Clark.

Nursing improvement project. On motion of Drs. Ellison and Clark, the committee voted to recommend to the Council that $1,000 be contributed for the nursing improvement project of the Indiana State Nurses' Association.

American Medical Education Foundation. By consent, the question of setting up a committee to solicit funds for the American Medical Education Foundation was referred to the Council.

On motion of Drs. Clark and Wright the executive secretary was directed to write the Delaware-Blackford County Medical Society that, in the committee's opinion, the resolution under consideration by the society which would set up a new method for paying physicians' fees under Mutual Medical Insurance, Inc., is unethical.

Hospital evaluation plan. It was taken by consent that the committee recommend to the Council that the A.M.A. delegates be instructed to support the hospital evaluation committee agreed upon by the American Hospital Association, the American College of Physicians, the American College of Surgeons, and the American Medical Association. This action was taken as a result of a resolution adopted by the Indiana Academy of General Practice urging the delegates to the A.M.A. to insist that the A.M.A. be the sole accrediting agency.

The committee, acting upon the request of the Indiana Academy of General Practice that the Executive Committee recommend a change in the association's by-laws to give each section one delegate representation in the House of Delegates, was referred back to the Indiana Academy of General Practice for presentation to the delegates.

Before any additional material is mailed with the ISMA News Flashes in the future, it must be approved by the chairman of the Committee on Public Relations.

The committee decided to purchase a half-page of space in the Indianapolis Press Club's Gridiron banquet program at a cost of $75.00, the money to be taken from the funds of the A.M.A. Campaign Coordinating Committee.

Dr. Bibler, a member of the Committee on Veterans Affairs and Rehabilitation, reported that his committee recommended the acceptance of the Veterans Administration contract for home care medical treatment of veterans, whereupon, upon the motion of Drs. Kennedy and Clark, the Veterans Affairs Committee was directed to sign the contract.



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Medical meetings. The committee directed the headquarters office to keep a schedule of medical meeting dates so that the information may be made available to organizations which wish to avoid conflicts in meetings.

A.M.A. meeting, Atlantic City. The field secretary was authorized to attend the A.M.A. meeting in Atlantic City June 11-15, 1951, on motion of Drs. Ellison and Clark.

The committee decided to meet some Sunday in June with leaders of the Woman's Auxiliary to discuss their activities for 1951-52, the date to be decided at the next meeting of the Executive Committee.

The Journal

Report on advertising;

Total advertising, April, 1950, $2,268.07
Total advertising, April, 1951, $2,181.83
Total advertising, first quarter, 1950, $6,296.51
Total advertising, first quarter, 1951, $6,729.82

On motion of Drs. Clark and Wright THE JOURNAL was authorized to spend up to $200.00 for reprints of an article on the Marion County medical civil defense plan which is to appear in the June issue, the reprints to be sold.

Requests of the general librarian of Indiana University Medical Center for the extra bound volumes of THE JOURNAL which are in the headquarters office was approved if Dr. Charles N. Combs who donated many of these volumes to the office gives consent.

There being no further business, the committee adjourned to meet again on Saturday evening, May 26, 1951, at the Athenaeum, Indianapolis.

COUNCILOR DISTRICT MEETINGS

FIRST DISTRICT

Dr. W. B. Challman of Mount Vernon was elected president of the First District Medical Society at the annual meeting held Tuesday, May 8, in the Hotel McCurdy, Evansville. Dr. Victor Huggins of Evansville was elected vice-president and Dr. Wendell C. Stover of Boonville was elected secretary-treasurer. Dr. Alfred Ellison, president of the Indiana State Medical Association, was the principal speaker. The meeting was held in conjunction with the May meeting of the Vanderburgh County Medical Society.

FOURTH DISTRICT

Dr. George S. Row of Osgood was elected alternate councilor at the Fourth District Medical Society meeting held in North Vernon on Wednesday, May 16. Society officers elected were Dr. Carl Henning of Hanover, president; Dr. George W. Macy of Columbus, vice-president, and Dr. Robert O. Zink of Madison, secretary.

Madison was selected as the 1952 meeting city with Columbus acting as host city in 1953. Future district meetings will be held either in late April or June.

In addition to a report by Dr. Charles Overpeck of Greensburg, councilor, and a short talk by Dr. J. William Wright of Indianapolis, president-elect of the Indiana State Medical Association, the program consisted of a discussion of medical and surgical diagnosis and treatment of common chest diseases by Drs. James S. Battersby and R. M. Vandivier, both of Indianapolis. Dr. B. W. Thayer of North Vernon, retiring district president, presided.

Members of the Woman's Auxiliary met at the home of Dr. and Mrs. Thayer in the afternoon. Mrs. A. W. Ratcliffe of Evansville, past president of the state auxiliary, was the speaker.

FIFTH DISTRICT

Dr. M. C. Topping of Terre Haute was elected councilor from the fifth district to replace Dr. A. M. Mitchell, who requested he be relieved of his duties due to his health. Doctor Mitchell had served as councilor since 1942, in addition to many other duties in association affairs.

Dr. Gilbert D. Rhea, Greencastle, was elected president; Dr. Opal L. Wood, Brazil, was elected vice-president and Dr. Charles N. Combs, Terre Haute was re-elected secretary-treasurer. The 1952 meeting is to be held on the second Wednesday in May at the Old Trails Inn, near Greencastle.

Fifty-three members of the district attended the scientific meetings, held in the Phoenix Country Club in the afternoon. Dr. J. Stanley Battersby, Indianapolis, gave a paper on "Surgical Conditions of Diseases of the Chest." Dr. Robert J. Rohn, Indianapolis, discussed "The Recognition and Management of the Hemorrhagic Disorders," and Dr. Paul Merrell, Indianapolis, presented a paper on "Herniated Nucleus Pulposus, Cervical and Lumbar."

The program closed with a dinner followed by a few remarks by Dr. Alfred Ellison, president of the Indiana State Medical Association, who discussed the activities of the association. Richard Mills of Indianapolis closed the meeting with a humorous lecture.

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SIXTH DISTRICT

Dr. F. B. Mountain of Connersville was elected president of the Sixth District Medical Society at the annual meeting held in Liberty on May 10. Dr. Harry P. Ross of Richmond was named vice-president and Dr. R. W. Kuhn of Wilkinson was re-elected secretary-treasurer.

The 1952 meeting will be held in Connersville, the date to be decided by the officers.

Dr. Alfred Ellison of South Bend, president of the Indiana State Medical Association, spoke at the luncheon. Present were Dr. J. William Wright of Indianapolis, president-elect, and Mrs. Francis Fargher of Michigan City, president of the state Woman's Auxiliary.

The scientific program consisted of the following:

"Coronary Heart Disease" by Dr. A. B. Brower of Dayton, Ohio.

"The Use of ACTH and Cortisone in Asthma" by Dr. W. H. Howard of Hammond.

"Medical Treatment of Thyrotoxicosis" by Dr. Virgil R. Hauenstein of Cincinnati, Ohio.

"Surgical Aspects of Thyrotoxicosis" by Dr. Vinton E. Siler of Cincinnati, Ohio.

"The Physician's Responsibility in Preventing the Use of Dangerous Drugs" by J. Harold Jones of the Division of Food and Drugs, Indiana State Board of Health, Indianapolis.

Dr. Walter U. Kennedy of New Castle, councilor, presented his annual report on activities of the state medical association. Dr. C. A. Canaday of New Castle, vice-president of the district society, presided in the absence of Dr. W. A. Thompson of Liberty, the president, who was confined to his home with illness.

TENTH DISTRICT

The Tenth Councilor District Medical Society held its spring meeting at Whiting on April 11. The program began with a 2:00 o'clock luncheon served by the American Maize Products Company, which was attended by fifty physicians and their wives, followed by a tour through the plant. Dr. Frank Sink, of Remington, president of the district, presided at the dinner meeting, which was attended by seventy-five physicians and their wives. Guest speakers for the evening were Dr. Carlo Scuderi, of the University of Illinois, who spoke on "Bone Surgery for Massive Long Bone Defects"; and Dr. Edward Holmblad, of Chicago, who spoke on "Doctor-Patient Relationships."

LOCAL SOCIETY REPORTS

Boone County Medical Society members met at Witham Memorial Hospital in Lebanon on May 1, to participate in the postgraduate telephone seminar. Twelve members were present.

The Dubois County Medical Society and members of the Woman's Auxiliary held a joint dinner meeting on April 12 at the Huntingburg Country Club. Twelve members were present to hear a transcription of an address on socialism, and to view a demonstration of a portable respirator.

Fayette-Franklin County Medical Society members held a meeting at the country club in Connersville on April 10, when treatment teams for the civil defense program were appointed. Guest speaker for the evening was Dr. John Warvel of Indianapolis, whose topic was "The Management of the Diabetic Patient." Twelve members were present.

Grant County Medical Society members participated in the postgraduate telephone seminar on May 1. This was the seventh in the series.

Greene County Medical Society members met in Linton on April 12, when eleven members were present. Dr. George Porter, of Linton, spoke on "The Merits of a County Immunization Program."

Hendricks County Medical Society members met in Avon on April 10, when Dr. Bennett Kraft, of Indianapolis, spoke on "Allergy in General Practice." Fourteen members and guests were present.

Howard County Medical Society members met at the Frances Hotel in Kokomo on May 3. Twenty-six members were present to hear Dr. Paul Fouts, of Indianapolis, speak on "Recent Developments in Hematology."

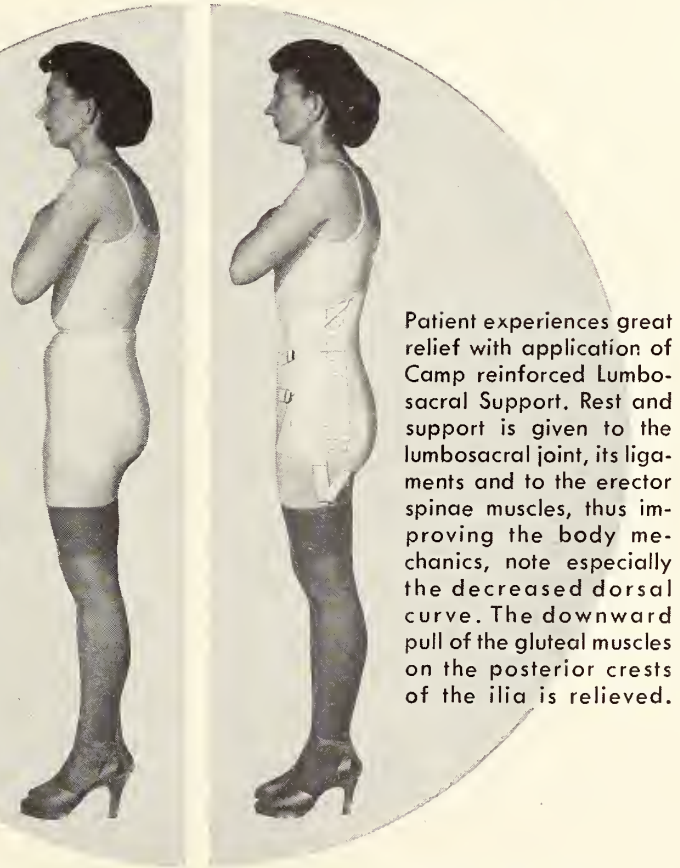
LaPorte County Medical Society members held a meeting at the Spaulding Hotel in Michigan City on April 19. Dr. Edwin Custer, of South Bend, spoke on "Certain Phases of Tuberculosis." Nineteen members were present.

Montgomery County Medical Society members met at the Culver Hospital in Crawfordsville on April 19. Dr. William Kirtley, of Indianapolis, spoke on "Types of Insulin Used in Treatment of Diabetes." Twenty-six members were present.

Monroe County Medical Society members listened in on the postgraduate telephone seminar on May 1.

Tippecanoe County Medical Society members held a meeting in Lafayete on April 9, when fifty members were present. The guest speaker was Dr. Donald H. Wrork, of Rockford, Illinois, who spoke on "Painful Afflictions of the Extremities."

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WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. D. E. Lybrook, Galveston.

President-elect—Mrs. F. M. Fargher, Michigan City.

Corresponding Secretary—Mrs. E. W. Bailey, Logansport.

Recording Secretary—Mrs. H. P. Sloan, New Albany.

Treasurer—Mrs. Robert Bolin, Elkhart.

Publicity—Mrs. F. M. Gastineau, Indianapolis.

The House of Delegates meeting of the Woman's Auxiliary to the Indiana State Medical Association was held in Terre Haute on April 26 and 27. The Vigo County Auxiliary with their president, Mrs. Robert Schumaker, as chairman, entertained 200 members and guests. Eighteen state officers and chairmen attended, also 8 councilors, 28 county presidents, 18 president-elects, and 63 delegates.

Two distinguished guests, Dr. Alfred Ellison of South Bend, president of the Indiana State Medical Association, and Dr. W. W. Bauer of Chicago, director of the Bureau of Health Education of the American Medical Association, spoke at the banquet in the Mayflower Room of the Terre Haute House. Both doctors stressed the importance of good public relations and unselfish service to fellow human beings.

At the close of the educational program, a fashion revue of authentic Gay Nineties clothes was presented with members of the Terre Haute Auxiliary acting as models. Mrs. J. E. Freed, Jr., was narrator and Mrs. Del Humphrey, pianist. The "Four Shades of Harmony" sang songs appropriate to the times depicted by the clothes and table decorations.

Mrs. Charles W. Sewall of Otterbein, administrative director of Associated Women of the American Farm Bureau Federation, a very dynamic speaker, talked at the luncheon meeting on "The Modern Ann McGinty." Mrs. Henry Bopp of Terre Haute conducted the memorial service.

Mrs. D. E. Lybrook of Galveston, state president, presided at all business sessions. Officers, chairmen, and county presidents all gave reports of the activities of the past year.

The afternoon program included reports of the resolutions and recommendations committees, election and installation of new officers, presentation of president's pin and gavel, and the inaugural address by Mrs. F. M. Fargher, incoming president. The sessions closed with the election of a nominating committee for next year and the post House of Delegates board meeting.

The following officers were elected: President-elect, Mrs. Hubert T. Goodman; First Vice-President, Mrs. George W. Wagoner; Second Vice-President, Mrs. W. J. Stangle; Third Vice-President, Mrs. Marvin F. Greiber; Fourth Vice-President, Mrs. Robert B. Johnson; Corresponding Secretary, Mrs. Victor F. Kling; Recording Secretary, Mrs. Elmer Singer; Treasurer, Mrs. Robert Bolin.

The organization owes the Terre Haute Auxiliary a vote of thanks for a very well planned and executed meeting.

The following report on the activities of the retiring president was made by Mrs. D. E. Lybrook:

INDIANA REPORT 1950-51

Again we are conscious of the active friendliness of our Indiana State Medical Association and the active interest they are taking in the work of our auxiliary. Doctor Black and the Executive Committee invited your auxiliary president and six of the auxiliary officers to meet with them to plan the program of the auxiliary year.

From this meeting we knew the doctors were interested in our work and the doctors learned of our interest in their work. We began the year happily—feeling that a good spirit of cooperation existed.

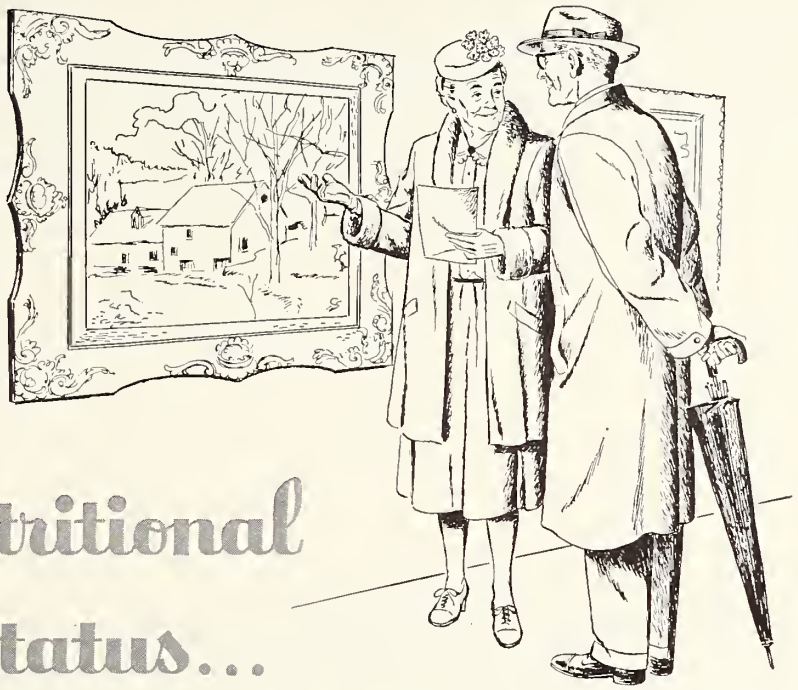
Organization continued on from the previous year. Eight counties were organized—making a total of 75 counties active in a program of 60 auxiliaries with a membership of 2,133 members.

Mr. Waggener, the field secretary of the Indiana State Medical Association, directed his efforts to those county medical societies by encouraging a public-relations program with the county membership and by selling the auxiliary plan to the doctors. As the state approaches the 100 percent organization figure, we have appreciated so much the aid the Indiana State Medical Association has given us by contacting the county medical societies in the unorganized areas. The society gave us fine publicity in the Indiana State Medical JOURNAL and the monthly state society publication, the News Flash. You have been pleased when your doctor commented by saying, "I read this auxiliary news item in my copy today."

You are aware of the state-wide publicity this House of Delegates meeting has had through the state and county level. This was the result your Publicity Chairman gained by help from the state office. Our "Hoosier Doctor's Wife" kept the entire auxiliary membership informed on the political issues before election and news pertaining to the fall and spring House of Delegates meetings.

The 13 Councilor District Auxiliaries were organized last year. This year I attended 8 Councilor District meetings. In the meetings the reports showed an increase in attendance, and an enthusiasm toward greater friendliness—both are goals of the organization. From these completed councilor district organizations, we are sure that each county auxiliary will become more aware of and be more concerned about the responsibilities and the opportunities to help the medical profession—another goal of auxiliary work. Doctor Gampell, formerly of England, and Miss Sally Butler of Indianapolis, had many speaking engagements in Indiana during the pre-election months—only two of many speakers so active in educating the public for a Voluntary Health Program. Again the state office helped us and the auxiliary stepped out in promoting election enthusiasm. Members distributed literature, talked to individuals and groups about Voluntary Health, educated voters and were baby-sitters and drivers on election day. One member prepared dinner so the mother in the home could go to the polls. That we *did* good work showed in the election results.

We have emphasized the 12 Point Program of the American Medical Association and tried to acquaint our members with the services available from the American Medical Association. Your speaker, Doctor Bauer, did make you feel that we have help and service available right now. The state and county auxiliaries, guided by the state medical society and the state board of health, have taken an active part in public health, school, community and rural health programs. Mrs. Caylor was appointed by Governor Schricker to membership on the Executive Committee of the "Indiana Council for Children and Youth," which is Indiana's adaptation of the Mid-Century White House Conference for Children and Youth."



Nutritional Status...

AN IMPORTANT FACTOR IN OLD AGE

A RECENT study[1] of the health and nutritional status of 200 elderly patients and their dietary habits revealed their food intake to be deficient in iron, calcium, protein, and, particularly, B complex vitamins. In many instances the lassitude and premature weakness of the elderly are due to such deficiencies.

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1. Bortz, E. L.: Management of Elderly Patients, Postgraduate Med. 3:186 (Mar.) 1950.

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COPPER	0.5 mg.	CALORIES	676

*Based on average reported values for milk.

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Our members have assisted in many health programs. From the county reports we can list: pre-school examination of children, immunization, diabetic detection, tuberculosis, cancer, heart, crippled children, social hygiene, mental hygiene, blood-typing, mobile x-ray, Red Cross, infantile paralysis, voluntary insurance—in fact, participation in everything pertaining to public health needs.

The Marion County Auxiliary assisted the Indiana State Medical Association and the state board of health in their booth at the State Fair. Many county auxiliaries promoted literature distribution, sale of "Today's Health," assisted at the public health and first aid booths at the County, 4H and Fall Festival Fairs.

Whether or not we like the thought, attacks and bombings may be our experience. At the Executive Committee meeting, your auxiliary offered the facilities and cooperation of the Indiana Auxiliary to Dr. G. W. Lee, the Civil Defense Chairman of the Indiana State Medical Association. Doctors will be the key men in all health work. So doctor's wives should be ready also to serve. Civil Defense pamphlets are already being distributed. Study yours and be prepared to aid when the time of disaster comes.

Thirty-six nurses' scholarships, essay contests, movies and Civil Defense work in blood-typing—each and all are public relations programs of your auxiliary.

The National Educational Campaign was presented by our Campaign Co-ordinating Chairman. Almost 2,400 resolution-endorsements, thousands of pieces of literature, many speakers from the Indiana State Medical Association carried a message of a Voluntary Health program to the citizens of Indiana. The result was shown by the vote in the 1950 elections.

Indiana ranks at the top among the states in resolution-endorsements and compares favorably in all auxiliary activities.

In the rural and community health program is a great opportunity for public relations work. Each auxiliary should try to have a responsible member as a representative in each lay group—to be especially willing to serve on program committees. Each auxiliary member through her chairman should become acquainted with the health facilities that are available and with those that are needed in her county. Educate yourself so that each one of you can say in regard to a voluntary program, "Let's do it ourselves."

For small groups—respond individually to calls for help in health drives, literature distributions, "To-Day's Health" promotion. Become members of lay study groups and be prepared to take part in programs directing a legislation study. When health councils are formed, be sure that your medical society is represented in an organizing group. Whatever the number of members, please be prompt in sending the list of officers to the auxiliary councilor, the president and the treasurer so that material may be sent to you promptly. If you do not receive communication from your state president or your state chairman, write again to them—they *ARE* trying to help you!

In organization, we could sponsor an organization of medical student's wives so they could more easily take their places in the state and county auxiliaries.

As president of this auxiliary, I represented this organization at the following:

(Continued on page 520)



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From The Literature

- Bubert and Cook, Bulletin of School of Medicine, Univ. of Maryland, Vol. 32, pp. 175-190, 1948.
- Paul and Montgomery, J. Iowa State Med. Soc., June, 1948.
- Krantz, Holbert, Iwamoto and Carr, J.A.Ph.A., Vol. 36, pp. 248-250, 1947.
- New and Non-official Remedies, 1950, p. 285.

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(Continued from page 518)

1. Two national conventions.
   a. National Conference of State Presidents and President-Elects.
   b. National Rural Health Conference.
2. Two county health conferences.
3. Rural Health Conference at Purdue University.
4. Indiana Mid-Century White House Conference.
5. Workshops at Indiana University.
6. Committee meetings.
   a. Community Health Organizations—a group representing 23 health-conscious organizations. This committee is concerned with creating public interest in legislature relative to establishing full time County Health Units—your legislative chairman is responsible for acquainting all of our county auxiliaries with this program and has kept up a large mailing list. Innumerable cards, letters, material were mailed to you.
   b. Public School Health.
   c. Rural Health.
   d. Board of Health—dedication of the Board of Health Building.
7. Attended 8 District Councilor Meetings.
8. Visited 21 auxiliaries.
9. Two board meetings.
10. Two state conventions.

I was your representative as a guest at the Illinois State Auxiliary Convention.

One thing, more than anything else, I would like to do before I leave the office of president is to bring to each of you the sense of belonging to one large organization which covers the entire country. I have been able to achieve this feeling only through attending a number of national meetings, with delegates from every state in the union. It is only when one hears members rom other states describing what they have been doing that one realizes we are working along the same lines, toward the same goals.

Without the feeling of oneness, it is sometimes difficult to understand the reasons for certain policies and for various aspects of our program. The American Medical Association asked for help from the wives of physicians in order that the physicians themselves might be relieved of some of the more arduous tasks, particularly in the field of politics. In response to its request, the Auxiliary has come to the front. Every state now has an auxiliary and there are auxiliaries in Alaska and the Hawaiian Islands. Our state has 60 auxiliaries.

The auxiliary has been given certain specific duties by the parent organization and these are passed to the states and from the states to the districts and from the districts on to the counties. The chief ones are: to help with all legislation which affects the medical profession, to act as good public relations representatives between the lay public and the profession, to encourage nurse recruitment and to aid in the dissemination of authentic health information. Those are definite requests and are not left to our own choice. To be effective, our activities must be part of the national pattern.

I have found that Indiana is everywhere held in high esteem, especially with regard to the quality of medical achievement attained here. The Indiana auxiliaries must live up to these high standards.



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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

PAUL EHRLICH. By Martha Marquardt, who for 13 years was secretary to the great pioneer in chemotherapy, discoverer of the "Magic Bullet" or Salvarsan (606). 255 pages, with illustrations. Price $3.50. Henry Schuman, Inc., 20 East 70th Street, New York 21, 1951.

CURRENT THERAPY 1951—Latest Approved Methods of Treatment for the Practicing Physician. Editor: Howard F. Conn, M.D. 699 pages. Price $10.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, 1951.

SURGICAL FORUM—Proceedings of the Forum Sessions; Thirty-Sixth Clinical Congress of the American College of Surgeons, Boston, Massachusetts, October, 1950. By the Surgical Forum Committee, Owen H. Wagensteen, M.D., chairman. 665 pages, 260 figures and 6 tables. Price $10.00. W. B. Saunders Company, 218 W. Washington Square, Philadelphia 5, 1951.

HEALTH PROGRESS IN THE UNITED STATES. By Mortimer Spiegelman, Fellow of the Society of Actuaries. 28 pages and 7 tables. Price 50c. No. 439 in the series "National Economic Problems." Published and distributed by the American Enterprise Association, Inc., 4 East 41st Street, New York 17, 1950.

1950 FACTS ABOUT NURSING. A statistical summary by the American Nurses' Association in cooperation with five other nursing organizations. 103 pages. Price 50 cents. American Nurses' Association, 2 Park Avenue, New York 19, 1950.

DIABETES GUIDE FOR THE PHYSICIAN. By the Committee on Education of the American Diabetes Association with foreword by Frank N. Allan, M.D. 79 pages. Any practicing physician who has not received his copy may obtain one free by writing American Diabetes Association, Inc., 11 West 42nd Street, New York 18, N. Y. Copyright 1950.

HOSPITAL STAFF AND OFFICE MANUAL. By Tadeusz M. Larkowski, M.D., F.A.C.S. and Albert R. Rosanova, R. Ph., M.D. 428 pages and hundreds of illustrations. Price $4.95. Romaine Pierson Publishers, Inc., 690 Northern Boulevard, Great Neck, L. I., New York, 1951.

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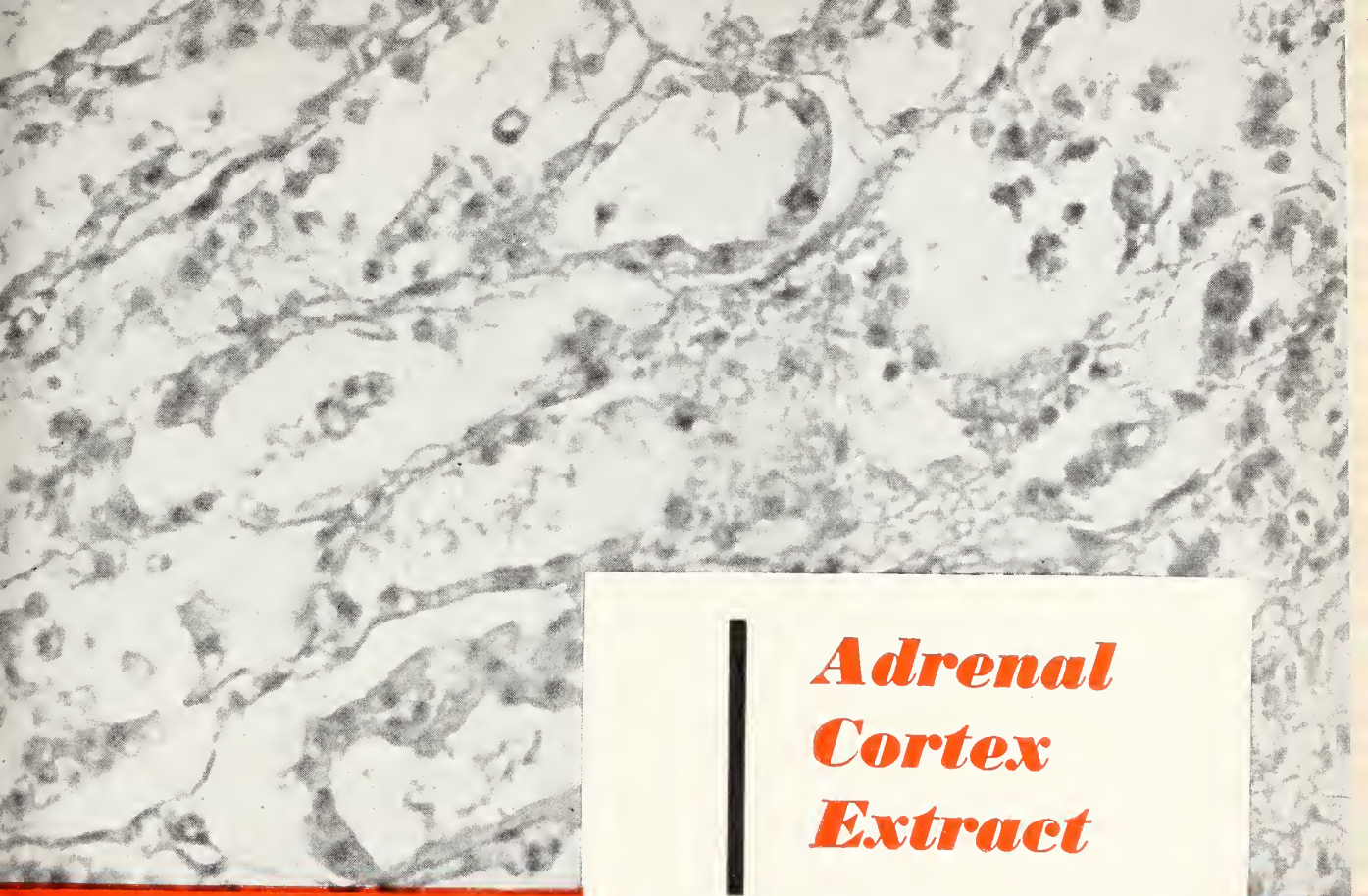
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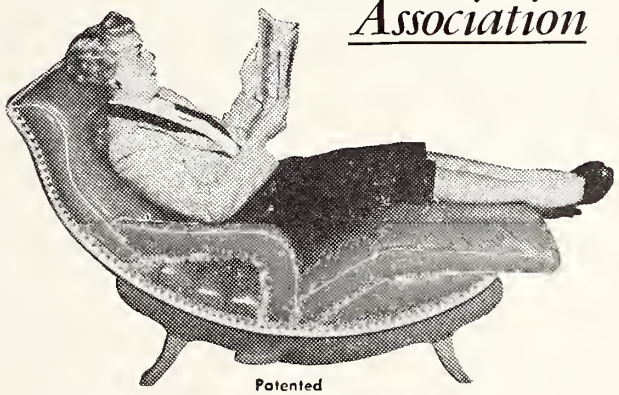
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INDIVIDUALS AND GROUPS IN MEDICAL PRACTICE

ALBERT STUMP*

INDIANAPOLIS

THE professional or medical advantages or disadvantages of working as an individual or as one of a group will not be included in this discussion. It will be only a general discussion of the way individual or group practice may be organized and carried on.

INDIVIDUAL PRACTICE

In an individual practice the doctor has his own office and equipment and is the owner of the business. Formerly it might have been improper to refer to a doctor's calling as a business, but since the decision in American Medical Association v. United States (1943), 317 U. S. 519, the use of that term has become legally correct.

Of course there are no problems of conflicting rights and duties where the individual owns and runs his own business and has no employees. But when the individual begins to employ others to assist in his business, then legal questions arise even though he still remains the owner of it and has the right to control and manage it. Questions may then arise as to the extent to which he may delegate his duties to others who may be employed by him, as to whether the person employed is employed in the capacity of a servant or in the capacity of an individual contractor, as to liability for the acts of his employees, as to taxes, and as to many other matters of which the law will take cognizance. This article will not deal with all the problems that can arise where the relationship of master and servant, or employer and independent contractor may exist. The line between group and individual practice is not always easily drawn. Where two or more physicians share the same office and reception rooms and use the same facilities and equipment, there may still be individual practice.

A distinguishing point between individual practice and group practice is whether the patient becomes the patient of just one physician who assumes the entire responsibility for the treatment of the particular condition which brought the patient to the office, or becomes the patient of two or more physicians who may not necessarily be in the same office but who have assumed joint responsibility for the treatment of the patient. The individual practitioner may hire other physicians, nurses, technicians and assistants of various kinds and be responsible for the acts that they perform within the scope of their employment so long as they occupy in relation to him the status of a servant.

Where the relationship of master and servant exists the master is responsible for the acts of his servant performed within the scope of his employment. But if the individual physician employs another physician and the patient is informed that such employee is to be responsible for the treatment and that such employed physician is to be guided by his own judgment and discretion and will work without any right or authority on the part of the employing physician to control his acts, then the employing physician is not liable for the acts of the employed one, for in that event the employed one is not a servant but is an independent contractor. Whether the employed physician occupies the one status or the other is generally a question of fact and may be very difficult to determine with accuracy. It may be the

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kind of question of fact upon which reasonable men under some circumstances might reach conflicting decisions.

The individual physician cannot delegate responsibilities that are his own to a servant and thereby divest himself of liability for mistakes in the performance of the duties attempted to be delegated. On the other hand the employing physician may effectually delegate his responsibilties to an independent contractor, with the consent and knowledge of the patient.

GROUP PRACTICE: PARTNERSHIPS

Group practice is frequently carried on in the form of a partnership. A partnership exists between physicians where two or more agree to share the profits and losses and to have joint management, control and ownership of the business. A partnership is not merely a group who have a common interest in a business or project. That interest may exist through ownership of stock in a corporation. Each partner is regarded by the law as an agent for himself and the one or more other persons forming the partnership. Such an agent is not the agent of an impersonal entity regarded as a creature separate from the individuals who make up the group. The agency is personal as to each member of the group constituting the partnership.

It follows that any member of a partnership may, by his own acts, bind himself and the other members of the partnership by obligations which he creates when acting within the scope of the partnership business. So if one partner incurs a debt for some expensive equipment, for instance, the debt becomes the debt of each of the partners separately as well as of all of them jointly. That is, the creditor may collect from the property of any one or more of the members of the partnership. He may obtain a judgment against the partnership and then levy execution of that judgment on the property of only one partner. Of course the partner who paid would have the right of contribution from the other partners of their proportionate shares. But so far as the creditor of the partnership is concerned, whatever any partner owns, whether connected with the business or not, is liable for the debt owed him by the partnership.

Suppose one partner is charged with malpractice. The ordinary procedure is not to bring the action just against one partner but against all the members of the partnership—on the theory that what the one partner did was being done in the carrying on of the business of the partnership; and that he, acting for himself and as agent for all the other partners, bound himself and them by his act to responsibility for whatever act was performed by him as a partner.

This liability of all the partners for the negligence of one may not seem quite consistent with what has been said regarding servants and independent contractors. That is, it might appear that each partner would be an independent contractor as to patients he himself treated. The element of consistency is to be found in the fact that the relationship of master and servant can exist only where someone has the right and power of management and control of another—and with partners the legal assumption is that all members of the firm together exercise the right and power to control and manage. So the partners cannot be separated on the basis that some have power and control and therefore are responsible as master, while the others do not have. Neither can one partner act in the scope of the partnership's business as an independent contractor, since all the partners have the general right to control the acts of each. The public is not charged with the knowledge of the internal structure of the partnership. If it has knowledge of the existence of the partnership it has the right to move on the assumption that the usual partnership rights and liabilities exist with respect to all the members, including even those who may be secret or silent members.

The disadvantages of a partnership may be briefly summarized as follows: The unlimited liability of each partner for the debts of the partnership, the joint management and control which may result in disagreements, the termination of the partnership through death or withdrawal of a partner. However, it would seem that the disadvantages could be outweighed by the advantages to be gained by a partnership where two or more physicians are working together. If one physician employs the other or others, then of course the death of the employing physician immediately presents a difficult problem, for then the employed physicians have to deal with the heirs or personal representatives of the decedent. The question of the transmission of the interest in the business that may have been built up by the combined efforts of the employer and employed physicians may be difficult to solve satisfactorily. The sole liability for the debts of the business with respect to the individual is a different matter from the unlimited liability of a member of a partnership. If some one member of the partnership pays a debt of the partnership he has a right of contribution from the other partners and thus may make his own burden lighter. There may be advantages also in the maintaining of the morale of the physicians who are in the group if they all have a share in the ownership, management and control. Of course this would depend upon elements of personality which might even work out so that a group of physicians of which one was the employer and the others were employees would have a more efficient and satisfactory operating group than if they were partners.

Even though a partnership terminates with the death or withdrawal of one partner there still may be provisions in the partnership agreement under which continuity can be preserved in the firm, and rights of heirs may be safeguarded. Even where one physician employs one or more others there

might also be in that contract some provision for continuity of the business built up through the fact of that group working together as a group.

From what has been said it will be seen that contracts of employment or of partnership must be of so many different kinds to meet different situations that the particular situation involved must be studied to determine whether it would be best to have a partnership contract or a contract of employment where two or more physicians work together.

GROUP PRACTICE: CORPORATIONS

A corporation itself, generally speaking, cannot practice medicine. In some states there are statutes on this subject, but where there are none it would still be impossible for a corporation to practice medicine in the same sense that an individual does. A corporation is regarded as a legal entity which does not consist of the individuals themselves who own the stock of the corporation. The individuals who incorporate create a thing that is separate from themselves, as has already been shown. That legal entity of course cannot take an examination. It cannot obtain a license. It cannot graduate from a recognized medical school. It has no corporeal existence. It exists only in contemplation of law, but in contemplation of law it has many rights and obligations of the same nature as a person. In fact, it is sometimes spoken of as a person.

Corporations may be organized either for profit or not-for-profit under the laws of the state of Indiana. Corporations for profit may be organized under the general corporation law of 1929 "for any lawful business purpose or purposes, except rural loan and savings associations, credit unions, or corporations for the conduct of banking, railroads, insurance, surety, trust, safe deposit, mortgage guaranty, or building and loan business." These excepted corporations are organized under special laws.

Corporations not-for-profit may be organized for any purpose consistent with the provisions of the law. They include but are not limited to religious, civil, social, educational, fraternal and charitable associations which do not engage "in any activities for the profit of its trustees, directors, incorporators, or members."

Medical schools, hospitals and such institutions are generally organized under the not-for-profit corporation act. Clinics are sometimes organized under the for-profit act.

Much has been said about corporations not being able to engage in the practice of medicine. Some of it has been misleading. In the state of Indiana, and in many other states, while a corporation as such cannot engage in the practice of medicine, it is lawful for the corporation to maintain an office, equipment, facilities and supplies to be used in the practice of medicine, and to employ physicians to render medical services to patients where the physicians are employed as independent contractors. Upon that point the Supreme Court of Indiana, in a case involving the question as to whether a corporation was practicing medicine or not, said this:

> "The facts justify the conclusion that the corporation charged and collected for the use of its hospital facilities and equipment, *and for furnishing the services of licensed and qualified physicians and surgeons.* Under such a contract the duty of the corporation, in respect to the physicians or surgeons, would be complied with by using reasonable and ordinary care to employ reasonably qualified, reputable, licensed physicians. In such a case the physicians and surgeons are independent contractors. . . . Such a contract may be assumed to be within the power of the corporation and *is not illegal.*" (Our emphasis.)

The case in which the statement just quoted was made was brought for malpractice against an incorporated clinic and a physician from that clinic who rendered the medical services. The court held that the incorporated clinic was not liable, since the doctor was an independent contractor, but that the verdict of the jury against the doctor would be affirmed.

Upon this same theory physicians are held to be independent contractors where they are employed by industries or insurance carriers to render medical services.

There are many advantages in having a group practice carried on through a corporation, and there are some disadvantages. If a corporation is made which employs physicians to render the services as independent contractors and which furnishes the equipment, supplies and facilities, then the debts which are incurred in the course of the business become the debts of the corporation. The corporation has whatever capital may be obtained by it through the sale of its stock and through the accumulation of capital assets as it carries on business. If the corporation becomes insolvent and is unable to pay its debts, those debts do not become the debts of the stockholders. They are the debts of that incorporeal creature of the law, which is the corporation. Thus the individual property of a member of the group, as for instance his home, cannot be taken for the payment of the debts of the corporation as it could be for individual debts or for debts of a partnership of which the individual might be a member.

The only thing the member of the corporation can lose if the corporation fails, is the money he has put into it. This limited liability is the reason for the existence of corporations generally. So if one buys stock, say in a railroad company, and the railroad company becomes insolvent, the creditors cannot come out and levy on the property of the

stockholders. But they could levy on the members of a partnership that might own the railroad.

The individual physician employed by a corporation as an independent contractor of course is liable for his own negligence or malpractice, but this does not create any liability on the part of the other doctors in the same group, as it does in a partnership.

If a group of doctors incorporate there is the possibility of tax problems arising which may not exist with a partnership. But if the organized group of physicians render only personal services and do not engage in other activities for profit, then the tax situation could generally be solved without difficulty through the salary arrangement that could be made between the physicians and the corporation. There would be no corporation federal income tax to pay unless the corporation made a net income. The gross income tax would result in an extra burden. Corporation reports are required to be made, but these are very simple and can be taken care of practically as easily as if the group operated as a partnership.

The corporation form of organization makes the preservation of continuity simple and easy. The death of one stockholder or physician in a group does not terminate the corporation. The stock interest can be so arranged and the sale of the stock can be so limited as to meet a wide range of contingencies, including illness, a desire to withdraw from the corporation, death, bringing in of additional or other doctors, and continuing payments to survivors. These provisions, or whatever other plans may be worked out, including those in regard to future interests, can be done more satisfactorily and expeditiously through a corporation form of organization than through a partnership.

So the possibility of carrying on a group practice through a corporation should not be overlooked because of any misapprehension regarding the limits of the power of a corporation under the Indiana laws.

The 1947 Indiana General Assembly passed a law requiring all physicians to report to the State Board of Health persons diagnosed as cases of epilepsy or similar disorders characterized by lapses of consciousness. The State Board of Health is required to forward these reports to the State Bureau of Motor Vehicles, and they are used by that agency to determine the eligibility of persons to operate a motor vehicle. The 1951 General Assembly passed a law with a similar wording except in this instance the State Board of Health also is directed to send a report to the State Aeronautics Commission.

In 1947 a report form was prepared for the convenience of physicians. The law of 1951 requires no additional action on the part of the physician but it does make it necessary for the State Board to send the reports to both the Bureau of Motor Vehicles and the Aeronautics Commission.

ADEQUATE INSURANCE AGAINST LIABILITY FOR MALPRACTICE

ALBERT STUMP*

INDIANAPOLIS

ONE of the questions that confront a physician in the management of his business is what amount of insurance against liability for malpractice he should regard as adequate. Is it enough to carry such insurance as will be sufficient ordinarily to pay the amount that the case could be settled for? Or should the physician carry enough to make reasonably sure that it will be sufficient to pay the amount for which an extraordinary case might be settled? Or should he carry enough that it may cover all possible situations in which liability may arise from any case in which he may be charged with malpractice?

The insurance principle in general is that losses which might be difficult for the individual to bear, even to the point of being catastrophic, are to be spread out both as to the number of years involved and as to the number of persons who will help share the loss, on the understanding that if they become victims of the same kind of misfortune their loss will likewise be shared by the others. What the insureds ordinarily seek is protection against a loss that to them would at least be burdensome if they had to bear the entire loss themselves. Activities which may result in small or insignificant liability ordinarily are not insured.

The amount of insurance one should carry should be determined by the amount of risk of loss and by the cost of the insurance.

It would seem that the best way to determine how much danger is involved of liability for malpractice on the part of those practicing medicine would be to ascertain what amounts have been fixed by the juries and sustained by courts as proper measures of damages for malpractice. The following amounts of judgments in malpractice cases have been given in Indiana in cases that come to mind:

Broken hip	$ 8,500.00
Sponge enclosed in laparotomy	8,500.00
Bad result in broken leg treated by two doctors,	
As to one doctor	15,000.00
As to the other doctor	10,000.00

All these cases were decided some time ago. The psychological effects of inflation are to be seen in some verdicts today. Sometimes the amounts of these verdicts are of shocking size where serious personal injuries are involved. One in New York was for $250,000.00 for loss of a right hand. One in California was for $185,000.00.

In 25 Corpus Juris Secundum, pages 915 to 917, is a long list of cases ranging from $10,000.00 up to $100,000.00 for personal injuries.

In malpractice cases the amounts are not so likely to go into the tens of thousands of dollars, for the reason that ordinarily there is some doubt and uncertainty about how much of the personal injury was due to the allegedly erroneous treatment and how much resulted from the original condition independently of any such treatment. But the same principles are applied for the measurement of personal injuries, whether resulting from malpractice or from any other type of negligence.

The maximum amount recoverable for wrongful death in Indiana has been increased from $10,000.00 to $15,000.00. This illustrates the tendency of juries and courts to increase the dollar value of injuries to compensate for the loss in the value of the dollar. Because of this tendency it is advisable that doctors review their insurance situations to determine whether they have adequate insurance to meet their needs, on whatever basis they determine their needs.

To aid physicians in surveying their malpractice insurance, the following table is submitted to show the amount of premiums required for malpractice insurance as the amount of insurance increases:

POLICY LIMITS	COST 1 Year Premium	COST 3 Year Premium
5/15000	$27.00	$ 67.50
10/30000	35.10	87.75
Additional cost for 10/30000	$8.10	$20.25
15/45000	38.34	95.85
Additional cost for 15/45000	3.24	7.10
20/60000	40.77	101.93
Additional cost for 20/60000	2.43	6.08
25/75000	42.66	106.65
Additional cost for 25/75000	1.89	4.72
25/100000	43.74	109.35
Additional cost for 25/100000	1.08	2.70
50/100000	48.06	120.15
Additional cost for 50/100000	4.32	10.80
50/150000	49.68	124.20
Additional cost for 50/150000	1.62	4.05
100/200000	54.00	135.00
Additional Cost for 100/200000	4.32	10.80

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You will note that the amount of insurance increases much more rapidly than the premium cost. The facts in this table are taken from the rate structure of St. Paul Mercury Indemnity Company, the company which a few years ago began writing a policy in the form requested by the Indiana State Medical Association, which company for that reason was recommended by the State Association for malpractice insurance.

Your attention is invited to the article on "Malpractice Insurance for Physicians in the Armed Services," published in the May issue of THE JOURNAL to inform the doctors about to enter the Armed Service that their responsibilities while performing medical services in the Armed Forces remain the same as in civilian practice; and that therefore they should give the same consideration to insurance against liability for malpractice if they are in the Armed Service as they would if they are engaged in civilian practice. The same considerations of coverage apply in both situations.

What has been said in this article on malpractice insurance applies with equal force in liability insurance in other lines, such as automobile and general liability.

HOSPITAL-PHYSICIAN RELATIONSHIPS

ALBERT STUMP*

INDIANAPOLIS

IT IS regrettable that occasional misunderstandings, though promptly solved in an atmosphere of good will and common sense, may still afford material for unfavorable publicity which results at least temporarily in bad public relations.

This is a time when everybody is under unusual strains and tensions. To escape from that condition people are bound to seek for their own solutions, and when they find what they believe to be the accurate solutions they become impatient and irritable with those who disagree. This sometimes leads to controversies that separate and estrange good fellows from each other, whose best interests require a spirit of unity and good will.

So it is that in the care of the sick in the hospitals there are three distinct groups who could clash with each other. They are the hospital managers, the nurses, and the physicians. From any conflict creating any bitterness in these groups against each other, only misfortune for all three groups could result. No one could be the winner. All would be losers.

Where such controversies have arisen they have generally developed out of small beginnings. Some irritation that could have been removed easily to begin with is allowed to continue until it has become a serious infection. If it had been given wise and understanding attention in the beginning, and the unfortunate results of a failure to apply the healing remedy could have been anticipated from the beginning, unfortunate consequences could have been avoided.

It is advisable that there be some group who may be charged with the responsibility of familiarizing themselves with possible points of disagreement, anticipate their developments and be prepared in advance to volunteer their good offices to keep the relationships between nurses, hospital administrators and physicians on a sound basis of understanding and good will. Fortunately a beginning has been made to organize such a group. The Indiana State Nurses Association, the Indiana State Hospital Association, and the Indiana State Medical Association were requested to send representatives to consider the creation of a joint committee with membership from each of the three associations. All three associations responded favorably to that suggestion, and a joint committee has been designated, each association naming three members. Further information will be presented as soon as a meeting can be held of this joint committee and the organization of it completed.

Fortunately all three associations realize the importance of the undertaking, and the necessity of a high degree of cooperation in the work the committee may be called upon to do. The progress made up to this point in obtaining a committee augurs well for its future usefulness in the relationships that exist between these groups in the care of the sick in the hospitals.

One of the sometimes perplexing problems in hospitals is the making of acceptable rules and regulations. Under the Hospital Licensing and Regulating Law the Hospital Council has adopted general rules and regulations to which hospitals must comply in order to receive and hold licenses to operate as hospitals. The Council has approached the discharge of its duties with a solicitous concern for the maintenance of the very best public relations as well as intergroup relations. It has not been arbitrary. It has developed its work

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cautiously and proceeded, not on the basis of exacting compliance with the law through force, but through obtaining it willingly by the persuasion which reasonableness in its own rules, regulations and demands upon hospitals, carries to those asked to comply with them.

Until the adoption of this law private hospitals were subject to no regulation other than such regulations regarding hygienic and sanitary conditions as apply to any other place where people would come together in like numbers; and to general police regulations of universal application. Under this new hospital law the framing of rules and regulations is still proceeding. Each hospital makes its own institutional rules and regulations, subject to the approval of the Hospital Council.

This making of local hospital rules and regulations has to be done to some extent through trial and error methods of research and progress. So this task is not one that can be brought to a final close through one short meeting which in a perfunctory manner adopts a set of rules and regulations prepared entirely in advance and expected to fit every hospital. But assistance in working out such local rules and regulations and in making such amendments thereafter as experience in a particular hospital may indicate, can reasonably be expected from the common effort of the three groups most affected by the rules and regulations.

It is hoped that the physicians of the state will cooperate wholeheartedly in the framing of rules and regulations for the hospitals in which they practice so that local conditions which are best known to local physicians, nurses, and hospital managers may be given adequate consideration in the rules and regulations, and the local problems thereby be satisfactorily solved. The joint committee representing the three groups on the statewide basis no doubt can be of great value serving as a clearing house of ideas from all over the state and bringing help to the local communities whose local people will carry the real responsibility in establishing and maintaining good intergroup and public relations.

PRACTICAL NURSE WAIVER

Caroline Hauenstein, R.N.*

INDIANAPOLIS

WITHIN the past ten years the services of practical nurses have been increasingly recruited in the hospitals and for home duties. Along with this trend has come the recognition by both practical nurses and registered nurses of the need for the establishment of suitable schools for training, promotion of licensure and development of adequate employment centers for the distribution of service. The practical nurses and registered nurses have worked together in trying to meet these needs with the result that over thirty states have enacted laws for the licensure of practical nurses and there has been an increase in the number of schools.

The Indiana Nurse Practice Act was rewritten by the 1949 General Assembly making provision for the licensure of practical nurses who have completed a one year course in an accredited school of practical nursing and who successfully pass the state board examination. In January 1950 the first school of practical nursing was opened in Indiana under the sponsorship of the Indianapolis Board of Education, known as the Indianapolis Public Schools, School of Practical Nursing, located at 23 North Rural Street, Indianapolis. Subsequently there have been approximately thirty-five graduates from the school who have passed the state board examination and been licensed as Licensed Practical Nurses by the Indiana State Board of Nurses' Registration and Nursing Education.

The 1951 General Assembly introduced an amendment to the Nurse Practice Act which includes a waiver clause that will give those persons who have been working as practical nurses in Indiana an opportunity to qualify for a license. This waiver is designed to allow all persons who have practiced practical nursing for two years in the past five year period, in the state of Indiana, prior to January 1, 1951, an opportunity to take a licensing examination, thus temporarily waiving the necessity for graduation from an accredited school.

All persons making application under this waiver are required to have the certification of two physicians who have been familiar with their nursing practice and are willing to recommend them for licensure.

The Indiana State Board of Nurses' Registration and Nursing Education is anxious that this information reach all persons eligible to qualify. The cooperation of the Indiana doctors is solicited in an effort to reach those persons.

Application blanks may be secured by writing to the Indiana State Board of Nurses' Registration and Nursing Education, 307 Ober Building, Indianapolis, Indiana. All applications under the waiver must be filed prior to January 1, 1952.

* Executive Secretary, Indiana State Board of Nurses' Registration and Nursing Education.

SAFE BIRTH AND WELL-BEING OF CHILDREN BORN OUT OF WEDLOCK

Robert E. Jewett, M.D.*

INDIANAPOLIS

THE accepted standard of modern society, among civilized nations, is that children should be born into a family sanctioned by marriage. Failure to comply with this standard brings a stigma upon the unmarried mother and her child. This stigma serves as a restraint to illicit relations between men and women, and this in turn safeguards the marriage standards of our social structure. However, the problems of the unmarried mother and the child born out of wedlock are far more common and much more a part of our general health and welfare problems than is commonly realized.

In the United States there are more than 130,000 illegitimate births per year, which averages approximately 3½ percent of all live births in the nation. The percentage of illegitimate births to total births varies between the states of the nation, being higher in the South; higher in the nonwhite than the white race; higher in urban than in rural areas and higher in the lower economic levels of our society. There is also a wide variation in the report of percentage of illegitimate births among the various nations. It is reported that approximately 10 percent of births in Sweden are illegitimate; 5 percent in Great Britain, and the rates may well be over 50 percent in Latin American and South American countries. Without access to the actual figures, we know that the rates are very high in Germany and probably higher in Russia.

In the state of Indiana in 1949 there were 93,949 live births reported. Of these, 1,946 were reported as births to unmarried mothers or 2.1 percent of the total. Out of the births to unmarried mothers, 1,316 were white or 1.5 percent of the total white births. Of 5,014 nonwhite births, 630 were illegitimate or 12.5 percent of births in this group. In addition to the reported births, we can estimate that at least 150 illegitimate births were unreported. If from 2 to 3 percent of infants are born out of wedlock in this state, what health and social welfare problems are involved?

Most of the illegitimate births occur to girls between the ages of 15 and 24 and more than half of these involve girls under 20. A large proportion of the unwed mothers involved leave their place of legal residence and render themselves ineligible for any public assistance in the county to which they move. In addition to this, many counties have public assistance policies which do not include medical and hospital care of the unmarried mother, and the majority of township trustees have policies which preclude providing care for the unmarried mother.

It can safely be said that the majority of unwed mothers pose a serious social problem to the community and state, whether they are residents or nonresidents. The child born out of wedlock involves both a social and health problem because if the unwed mother is not provided with good living facilities and good medical care, the well-being of the infant is jeopardized and the child may become a problem for medical rehabilitation and social assistance for years to come. All of these may be of great cost to the community and the state.

As other evidence of the health factor involved with the problem of children born out of wedlock, more than twice as many stillbirths occur in this group as compared with the average. The unwed mother also involves health problems, since if she is not given care and guidance, she may be led to seek some method of disposing of the unborn child in great jeopardy to herself and to the child.

There are county and community services for unmarried mothers, but there are wide variations in the limitations and effectiveness of services given. County Departments of Public Welfare are legalized child placement agencies and they may provide one or several services for the unmarried mother, depending on the plan and policies adopted by the county departments and their resources. Some county departments provide for boarding home care of the expectant mother, adequate medical and hospital care and follow-up guidance for the mother and placement of the child. Some of these may also provide for financial assistance in the same manner for an unwed mother who has moved to another county. Some county departments are limited by policies or resources to the extent that they provide no care for the unmarried mother either within or outside of the county of residence. Township Trustees are often bound by their own policy restrictions or resources to the extent that they provide no assistance for the unmarried mothers and, if they do, a plan for services and care is usually very limited. In general, the majority of these public agencies, the County Departments of Public Welfare and the Township Trustees, will not or cannot provide adequate guidance and service for the unmarried mother.

One of the better facilities for care of the unwed mother and the child born out of wedlock is the

* Director Division of Maternal and Child Health, Indiana State Board of Health.

licensed maternity home or hospital. There are three such homes licensed as hospitals in the state of Indiana, but these homes at present can accommodate only about 150 to 160 girls a year. There are two or three other approved homes which provide for domiciliary care of the mother until the time of delivery, but all told these could not accommodate more than 150 girls a year. We may safely assume that well over half of the unmarried mothers are displaced from their legal residence and in need of such assistance. This must mean that from 700 to 1,500 unwed mothers are futilely seeking for help and guidance each year in Indiana.

The State Department of Public Welfare and the State Board of Health cooperate with plans to give a limited amount of assistance to unmarried mothers and infants born out of wedlock. Both programs have strict and arbitrary limits and they are maintained, largely, to meet unmet needs and to bring to the attention of the people the shortcomings of community planning and resources for these needed services throughout the state. The program of the Department of Public Welfare provides for boarding home care, and the Division of Maternal and Child Health of the State Board of Health provides for medical and hospital care. However, these programs limit services to the displaced girl and provide for care only when all other resources have been checked and found wanting. In addition, the State Department of Public Welfare is legally responsible for approval of boarding homes and institutions for children, child placement agencies, and adoption procedures.

There is an entirely different aspect to this whole problem, but one which very much indicates the need for society to put forth an effort to aid the unmarried mother and to safeguard the child born out of wedlock. The demand of married couples who are seeking to adopt children is great and the number far exceeds the number of children available for placement. These eligible couples have every right to expect that any child they accept has had good care before, during and after birth and is a safe prospect for their parental affection and attention.

The great needs which these statements indicate may be summarized. First, the people of the state and in each community must realize that the problem of the unmarried mother is numerically large, without evidence of decline, and a health and social responsibility which each community should meet. Counties and communities should be prepared to pay for good care of the unwed mother and for the safe birth of an adoptive child, and they should broaden county plans to provide for care outside of the place of residence for the displaced girl. One of the best solutions would be more and larger maternity hospitals for unwed mothers, but even with these adequate facilities, family resources, or help from the place of residence of the unmarried mothers must be available to maintain the institutions.

The Instructional Course Program is being planned for the 1951 Session of the Indiana State Medical Association to be held in Indianapolis October 29, 30 and 31. The courses will be given on Monday, October 29, beginning at 11:00 a.m. and continuing throughout the afternoon.

Arrangements have been made for the Indiana Academy of General Practice to give credit to members of that organization who attend the Instructional Courses. This is an additional and highly complimentary recognition of the value of this portion of the Annual Session of the Indiana State Medical Association.

The schedule of classes and the reservation blank will appear in THE JOURNAL for August. It is again urged that those who wish to attend this Instructional Course make prompt reservation, as the class limit of 30 will be enforced as usual.

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Medical Convention		
*Livingston Dunlap, Indianapolis	1849	1849
Medical Society		
*William T. S. Cornett, Versailles	1849	1850
*Ashahel Clapp, New Albany	1850	1851
*George W. Mears, Indianapolis	1851	1852
*Jeremiah H. Brower, Lawrenceburg	1852	1853
*Elizur H. Deming, Lafayette	1853	1854
*Madison J. Bray, Evansville	1854	1855
*William Lomax, Marion	1855	1856
*Daniel Meeker, LaPorte	1856	1857
*Talbot Bullard, Indianapolis	1857	1858
*Nathan Johnson, Cambridge City	1858	1859
*David Hutchinson, Mooresville	1859	1860
*Benjamin S. Woodworth, Ft. Wayne	1860	1861
*Theophilus Parvin, Indianapolis	1861	1862
*James F. Hibberd, Richmond	1862	1863
*John Sloan, New Albany	1863	----
*John Moffett (acting), Rushville	1863	1864
*Samuel L. Linton, Columbus	1864	----
*Wilson Lockhart (acting), Danville	1864	1865
*Myron H. Harding, Lawrenceburg	1865	1866
*Vierling Kersey, Richmond	1866	1867
*John S. Bobbs, Indianapolis	1867	1868
*Nathaniel Field, Jeffersonville	1868	1869
*George Sutton, Aurora	1869	1870
*Robert N. Todd, Indianapolis	1870	1871
*Henry P. Ayres, Ft. Wayne	1871	1872
*Joel Pennington, Milton	1872	1873
*Isaac Casselberry, Evansville	1873	----
*Wilson Hobbs (acting), Knightstown	1873	1874
*Richard E. Houghton, Richmond	1874	1875
*John H. Helm, Peru	1875	1876
*Samuel S. Boyd, Dublin	1876	1877
*Luther D. Waterman, Indianapolis	1877	1878
*Louis Humphreys, South Bend	1878	----
*Benj. Newland (acting), Bedford (v.p.)	1878	1879
*Jacob R. Weist, Richmond	1879	1880
*Thomas B. Harvey, Indianapolis	1880	1881
*Marshall Sexton, Rushville	1881	1882
*William H. Bell, Logansport	1882	1883
*Samuel E. Mumford, Princeton	1883	1884
*James H. Woodburn, Indianapolis	1884	1885
*James S. Gregg, Ft. Wayne	1885	1886
*General W. H. Kemper, Muncie	1886	1887
*Samuel H. Charlton, Seymour	1887	1888
*William H. Wishard, Indianapolis	1888	1889
*James D. Gatch, Lawrenceburg	1889	1890
*Gonsolvo C. Smythe, Greencastle	1890	1891
*Edwin Walker, Evansville	1891	1892
*George F. Beasley, Lafayette	1892	1893
*Charles A. Daugherty, South Bend	1893	1894
*Elijah S. Elder, Indianapolis	1894	----
Charles S. Bond (acting), Richmond	1894	1895
*Miles F. Porter, Ft. Wayne	1895	1896
*James H. Ford, Wabash	1896	1897
*William N. Wishard, Indianapolis	1897	1898
*John C. Sexton, Rushville	1898	1899
*Walker Schell, Terre Haute	1899	1900
*George W. McCaskey, Ft. Wayne	1900	1901
*Alembert W. Brayton, Indianapolis	1901	1902
*John B. Berteling, South Bend	1902	1903
Medical Association		
*Jonas Stewart, Anderson	1903	1904
*George T. MacCoy, Columbus	1904	1905
*George H. Grant, Richmond	1905	1906
*George J. Cook, Indianapolis	1906	1907
*David C. Peyton, Jeffersonville	1907	1908
*George D. Kahlo, French Lick	1908	1909
*Thomas C. Kennedy, Shelbyville	1909	1910
*Frederick C. Heath, Indianapolis	1910	1911
*William F. Howat, Hammond	1911	1912
*A. C. Kimberlin, Indianapolis	1912	1913
*John P. Salb, Jasper	1913	1914
*Frank B. Wynn, Indianapolis	1914	1915
*George F. Keiper, Lafayette	1915	1916
*John H. Oliver, Indianapolis	1916	1917
*Joseph Rilus Eastman, Indianapolis	1917	1918
William H. Stemm, North Vernon	1918	1919
*Charles H. McCully, Logansport	1919	1920
*David Ross, Indianapolis	1920	1921
*William R. Davidson, Evansville	1921	1922
*Charles H. Good, Huntington	1922	1923
*Samuel E. Earp, Indianapolis	1923	1924
Eldridge M. Shanklin, Hammond	1924	1925
Charles N. Combs, Terre Haute	1925	1926
*Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1926	1928
Charles E. Gillespie, Seymour	1927	1929
*Angus C. McDonald, Warsaw	1928	1930
*Alois B. Graham, Indianapolis	1929	1931
Franklin S. Crockett, Lafayette	1930	1932
Joseph H. Weinstein, Terre Haute	1931	1933
*Everett E. Padgett, Indianapolis	1932	1934
*Walter J. Leach, New Albany	1933	1935
Roscoe L. Sensenich, South Bend	1934	1936
*Edmund D. Clark, Indianapolis	1935	1937
Herman M. Baker, Evansville	1936	1938
*Edmund M. Van Buskirk, Ft. Wayne	1937	1939
Karl R. Ruddell, Indianapolis	1938	1940
Albert M. Mitchell, Terre Haute	1939	1941
Maynard A. Austin, Anderson	1940	1942
Carl H. McCaskey, Indianapolis	1941	1943
Jacob T. Oliphant, Farmersburg	1942	1944
Neslen K. Forster, Hammond	1943	1945
Jesse E. Ferrell, Fortville	1944	1946
Floyd T. Romberger, Lafayette	1945	1947
Cleon A. Nafe, Indianapolis	1946	1948
Augustus P. Hauss, New Albany	1947	1949
C. S. Black, Warren	1948	1950
Alfred Ellison, South Bend	1949	1951

* Deceased.

APPROVED HOSPITALS IN INDIANA*

January 1, 1951

ADAMS COUNTY

Miss Florence Lichtenstiger, R.N., Supt.
Adams County Memorial Hospital.
733 Mercer Ave., Decatur.

ALLEN COUNTY

Mr. Donald C. Carner, Supt.
Fort Wayne Methodist Hospital, Inc.
119 W. Lewis St., Fort Wayne.

O. T. Kidder, M.D., Supt.
Irene Byron Sanatorium.
R. R. 13, Lima Road North, Fort Wayne.

Mrs. Margaret Schuh, R.N., Supt.
Allen County Isolation Hospital.
R. R. 13, Fort Wayne.

Mr. E. C. Moeller, Supt.
The Lutheran Hospital of Fort Wayne.
3024 Fairfield Ave., Fort Wayne.

Sister M. Geroldine, Administrator.
St. Joseph Hospital.
730 W. Berry St., Fort Wayne.

BARTHOLOMEW COUNTY

Miss Olive M. Murphy, R.N., Administrator.
Bartholomew County Hospital.
East 17th St., Columbus.

BLACKFORD COUNTY

_____ Administrator.
Blackford County Hospital.
503 E. Van Cleve St., Hartford City.

BOONE COUNTY

Mrs. Lottie M. Dodson, Business Manager.
Witham Memorial Hospital.
1124 N. Lebanon St., Lebanon.

CASS COUNTY

Miss Macie N. Knapp, R.N., Supt.
Memorial Hospital.
1101-1115 Michigan Ave., Logansport.

Sister Joachime, Supt.
St. Joseph Hospital.
26th and North Sts., Logansport.

CLARK COUNTY

Mr. William McAlexander, Supt.
Clark County Memorial Hospital.
210 Sparks Ave., Jeffersonville.

CLAY COUNTY

Miss Helen L. Broughton, R.N., Supt.
Clay County Hospital.
1206 E. National Ave., Brazil.

CLINTON COUNTY

Miss Maude M. Woodard, R.N., Supt.
Clinton County Hospital.
1300 S. Jackson St., Frankfort.

DAVIESS COUNTY

Mrs. Olive B. DeHart, R.N., Administrator.
Daviess County Hospital.
1307 Bedford Road, Washington.

DECATUR COUNTY

Miss Ethel C. Stinger, R.N., Supt.
Decatur County Memorial Hospital.
720 N. Lincoln St., Greensburg.

DEKALB COUNTY

Bonnell M. Souder, M.D., Supt.
Dr. Bonnell M. Souder Hospital.
206 W. 7th St., Auburn.

Sister Kunigunda, Supt.
Sacred Heart Hospital.
220 Ijam St., Garrett.

Jesse A. Sanders, M.D., Administrator.
Sanders General Hospital.
1007 S. Main St., Auburn.

DELAWARE COUNTY

Miss Nellie G. Brown, R.N., Supt.
Ball Memorial Hospital.
2401 University Ave., Muncie.

DUBOIS COUNTY

Harvey K. Stork, M.D., Administrator.
The Stork Hospital.
530 4th St., Huntingburg.

ELKHART COUNTY

Mr. Emery K. Zimmerman, Administrator.
Elkhart General Hospital.
1100 South Boulevard, Elkhart.

Mrs. Lois Sinner, Act. Supt.
Goshen Hospital.
112-116 N. 5th St., Goshen.

FAYETTE COUNTY

Mr. J. W. Myers, Supt.
Fayette Memorial Hospital.
1941 Virginia Ave., Connersville.

FLOYD COUNTY

Sister M. Joan, R.N., Supt.
St. Edward Hospital.
703 E. Spring St., New Albany.

J. V. Pace, M.D., Supt.
Silvercrest.
(Southern Indiana Tuberculosis Hospital)
New Albany.

FULTON COUNTY

Miss Bernice Rannells, R.N., Supt.
Woodlawn Hospital.
624 Pontiac St., Rochester.

GIBSON COUNTY

Mrs. Dorothy G. Adams, R.N., Supt.
Gibson General Hospital.
419 W. State St., Princeton.

R.W. Wood, M.D., Administrator.
Wood Hospital and Clinic.
211 N. Gibson St., Oakland City.

* Approved by the Indiana Council for Hospital Licensure and the Indiana State Board of Health.

GRANT COUNTY

Miss Amy J. Daniels, Administrator.
Marion General Hospital.
Wabash and Euclid, Marion.

GREENE COUNTY

Mr. Avery Murray, Supt.
Freeman Greene County Hospital.
410 "A" St., N.E., Linton.

HAMILTON COUNTY

Miss Kittie McKelvey, R.N., Supt.
Hamilton County Hospital.
R. R. 4, Noblesville, Ind.

HARRISON COUNTY

Miss Anna O'Grady, Supt.
Harrison County Hospital.
Corydon.

HENRY COUNTY

Mr. Herbert A. Schacht, Administrator.
Henry County Hospital.
Rural St., New Castle.

Walter M. Stout, M.D., Supt.
The Clinic.
1319 Church St., New Castle.

HOWARD COUNTY

Sister M. Louise, R.N., Administrator.
St. Joseph Memorial Hospital.
1807 W. Sycamore St., Kokomo.

HUNTINGTON COUNTY

Miss Maude Harlow, R.N., Supt.
Huntington County Hospital.
1215 Etna Ave., Huntington.

JACKSON COUNTY

Mr. Ralph W. Keyes, Administrator.
Jackson County Schneck Memorial.
Bruce and Poplar St., Seymour.

JASPER COUNTY

Mrs. Ruth Schumaker, R.N., Supt.
Jasper County Hospital.
216-224 S. Cullen St., Rensselaer.

JAY COUNTY

Mr. W. I. Fender, Jr., Supt.
Jay County Hospital.
505 W. Arch St., Portland.

JEFFERSON COUNTY

Mrs. Rinda F. Rains, R.N., Supt.
King's Daughters' Hospital.
112 Presbyterian Ave., Madison.

JOHNSON COUNTY

Mrs. Ruth Raisin, R.N., Administrator.
Johnson County Memorial Hospital.
R. R. 1, Franklin.

KNOX COUNTY

Miss Dee Elsome, Supt.
Good Samaritan Hospital.
410 S. 7th St., Vincennes.

R. C. Meyer, M.D., Supt.
Hillcrest Tuberculosis Hospital.
North 2nd St. Road, Vincennes.

KOSCIUSKO COUNTY

Mrs. Faye O. Downs, R.N., Administrator.
McDonald Hospital.
Center and Parker Road, Warsaw.

Mrs. Samuel C. Murphy, Administrator.
Murphy Medical Center.
101 W. Winona Ave., Warsaw.

LAGRANGE COUNTY

Miss Edythe Gappinger, R.N., Supt.
LaGrange County Hospital.
LaGrange.

LAKE COUNTY

Philip H. Becker, M.D., Supt.
James O. Parramore Hospital.
R. R. 5, Crown Point.

Mr. R. B. Glesne, Act. Supt.
The Methodist Hospital of Gary, Inc.
1600 W. 6th Ave., Gary.

Sister Mary Reginald, R.N., Administrator.
Mount Mercy Hospital and Sanitarium.
Lincoln Highway and Joliet St., Dyer.

Sister M. Vetusa, R.N., Supt.
St. Catherine Hospital.
4321 Fir St., East Chicago.

Sister M. Amelia, R.N., Administrator.
St. Margaret Hospital.
25 Douglas St., Hammond.

Sister M. Alphonsine, Administrator.
St. Mary Mercy Hospital.
540 Tyler St., Gary.

LAPORTE COUNTY

Mr. Ernest I. Hoover, Administrator.
Fairview Hospital Association, Inc.
215 Pine Lake Ave., LaPorte.

H. L. Brooks, M.D., Administrator.
Clinic Hospital.
125-133 E. 5th St., Michigan City.

Sister M. Fidelis, R.N., Administrator.
Holy Family Hospital.
205 "E" St., LaPorte.

Sister M. Albertinia, R.N., Supt.
St. Anthony Hospital.
Wabash and Ann Sts., Michigan City.

Mr. Stanley E. Giese, Administrator.
Warren Hospital, Inc.
719 Franklin St., Michigan City.

LAWRENCE COUNTY

Mrs. Helen Boyer, R.N., Supt.
Dunn Memorial Hospital.
1616 23rd St., Bedford.

MADISON COUNTY

Sister Andrea, R.N., Supt.
Mercy Hospital.
2331 South "A" St., Elwood.

Sister M. Margaret Anne, Administrator.
St. John's Hickey Memorial Hospital.
127 W. 19th St., Anderson.

Miss Clara M. Lenz, R.N., Administrator.
Citizens Nursing Center.
431 Citizens Bank, Anderson.

MARION COUNTY

Charles W. Myers, M.D., Supt.
Indianapolis General Hospital.
960 Locke St., Indianapolis.

Mr. J. B. H. Martin, Administrator.
James Whitcomb Riley Hospital for Children.
I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.

Mr. Robert E. Neff, Supt.
Methodist Hospital of Indiana, Inc.
1604 N. Capitol Ave., Indianapolis.

Mr. J. B. H. Martin, Administrator.
Robert W. Long Hospital.
I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.

Very Rev. August R. Fussenegger, Supt.
St. Elizabeth Maternity Hospital and Infant Home.
2500 Churchman Ave., Indianapolis.

Sister M. Alexia, Superior.
St. Francis Hospital.
Sherman Drive and Troy Ave., Beech Grove.

Sister Lydia, Administrator.
St. Vincent's Hospital.
120 W. Fall Creek Parkway, Indianapolis.

Mrs. Ruth Henderson, Executive Director.
Suemma Coleman Home.
2044 N. Illinois St., Indianapolis.

Frank L. Jennings, M.D., Supt.
Marion County Tuberculosis Hospital.
Sunnyside Sanatorium, R. R. 12, Box 233, Indianapolis.

Mr. J. B. H. Martin, Administrator.
William H. Coleman Hospital for Women.
I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.

MARSHALL COUNTY

Mr. Robert Yoder, Supt.
Community Hospital of German Township, Inc.
411 Grant St. Bremen.

Mr. Herbert A. Boblett, Supt.
Parkview Hospital.
1401 N. Michigan St., Plymouth.

MIAMI COUNTY

_____, Supt.
Dukes-Miami County Hospital.
12th and Grant Sts., Peru.

Mr. W. E. Gollings, Supt.
Wabash Employees Hospital Association.
North Broadway, Peru.

MONROE COUNTY

Miss Anna G. Nelson, Administrator.
Bloomington Hospital.
640 S. Rogers St., Bloomington.

MONTGOMERY COUNTY

Mr. Ralph M. Hass, Administrator.
Montgomery County Culver Union Hospital.
308 Binford St., Crawfordsville.

MORGAN COUNTY

K. E. Comer, M.D., Supt.
Comer Sanitarium.
130 N. Indiana St., Mooresville.

Mrs. Mabel E. TerBush, R.N., Supt.
Morgan County Memorial Hospital.
190 S. Main St., Martinsville.

NOBLE COUNTY

Harold A. Luckey, M.D., Supt.
Luckey Hospital.
Wolflake.

Sister M. Ludgeria, Administrator.
Kneipp Springs Sanatorium.
Rome City.

Mrs. Beulah J. Burns, R.N., Supt.
McCray Memorial Hospital.
Hospital Drive, Kendallville.

ORANGE COUNTY

Ivan A. Clark, M.D., Administrator.
Clark Hospital, Inc.
308 E. Main St., Paoli.

PARKE COUNTY

Robert A. Staff, M.D., Supt.
Indiana State Sanatorium.
R. R. 1, Rockville.

PERRY COUNTY

Mrs. Pauline Churchill, Supt.
Perry County Memorial Hospital.
Star Route, Tell City, Ind.

PORTER COUNTY

Mr. R. Edwin Hawkins, Administrator.
Porter Memorial Hospital.
814 LaPorte Ave., Valparaiso.

PULASKI COUNTY

Thomas E. Carneal, M.D., Administrator.
Carneal's Private Hospital.
111 N. Monticello St., Winamac.

PUTNAM COUNTY

Mary Catherine Finn, R.N., Supt.
Putnam County Hospital.
322 Greenwood Ave., Greencastle.

RANDOLPH COUNTY

Mr. Vernon W. Hyer, Bus. Administrator.
Randolph County Hospital.
Greenville Ave., Winchester.

Mrs. Marcella Kantner, R.N., Supt.
Union City Hospital.
702 W. Division St., Union City.

RIPLEY COUNTY

Sister M. Gerard, R.N., Administrator.
Margaret Mary Hospital.
Rosemont Division, Batesville.

William J. Warn, M.D., Administrator.
The Whitlatch Clinic and Hospital, Inc.
Milan.

RUSH COUNTY

Mr. W. G. Humes, Supt.
Rush Memorial Hospital.
Main at 13th St., Rushville.

SCOTT COUNTY

Floyd S. Napper, M.D., Administrator.
Napper Hospital.
69 Wardell St., Scottsburg.

SHELBY COUNTY

Mrs. Frances Pruitt, R.N., Supt.
William S. Major Hospital.
150 W. Washington St., Shelbyville.

ST. JOSEPH COUNTY

E. W. Custer, M.D., Supt.
Healthwin Hospital.
R. R. 5, Darden and Laurel Roads, South Bend.

Mr. Alvan A. Sauer, Supt.
Northern Indiana Children's Hospital.
1234 N. Notre Dame Ave., South Bend.

Mrs. Ella Mae Dunlap, Act. Administrator.
Memorial Hospital of South Bend.
604 N. Main St., South Bend.

Sister M. Odilo, R.N., Administrator.
St. Joseph Hospital.
1215 W. 4th St., Mishawaka.

Sister Miriam Dolores, R.N., Administrator.
St. Joseph's Hospital.
401 N. Notre Dame Ave., South Bend.

A. F. Kull, D.O., Administrator.
South Bend Osteopathic Hospital.
118 S. William St., South Bend.

STEUBEN COUNTY

Mrs. Daisy McCallister, R.N., Supt.
Cameron Hospitals, Inc.
416 E. Maumee, Angola.

Miss Bessie Cottrell, R.N., Administrator.
Elmhurst Hospital, Inc.
609 W. Maumee, Angola.

SULLIVAN COUNTY

Miss Mabel A. Cook, R.N., Administrator.
Mary Sherman Hospital.
320 N. Section St., Sullivan.

TIPPECANOE COUNTY

Mr. T. E. Berg, General Manager.
Lafayette Home Hospital.
2400 E. South St., Lafayette.

Sister M. Sponsaria, Administrator.
St. Elizabeth Hospital.
1021 N. 14th St., Lafayette.

J. W. Strayer, M.D., Supt.
William Ross Sanatorium.
State Road No. 52, Lafayette.

TIPTON COUNTY

Mr. Harry L. Gable, Administrator.
Tipton County Memorial Hospital.
Tipton.

VANDERBURGH COUNTY

Paul D. Crimm, M.D., Supt.
Boehne Tuberculosis Hospital.
Upper Mount Vernon Road, Zone 12, Evansville.

Mr. Albert G. Hahn, Administrator.
Protestant Deaconess Hospital.
600-700 Mary St., Evansville.

Sister Justina, Administrator.
St. Mary's Hospital, Inc.
713 First Ave., Evansville.

Mr. Crayton E. Mann, Administrator.
Welborn Memorial Baptist Hospital, Inc.
412 S.E. 4th St., Evansville.

VERMILLION COUNTY

Miss Hannah Rosser, R.N., Administrator.
Vermillion County Hospital.
1801 S. Main St., Clinton.

VIGO COUNTY

Mrs. Arlie Dwyer, R.N., Supt.
Florence Crittendon Home.
1923 Poplar St., Terre Haute.

J. J. Hoover, M.D., Supt.
Hoover Sanatorium.
2144 8th Ave., Terre Haute.

Sister M. Stephanina, Administrator.
St. Anthony Hospital.
1021 S. 6th St., Terre Haute.

I. Herman Sloss, M.D., Administrator.
Sloss Hospital.
1029 S. 7th St., Terre Haute.

Mr. Frank R. Briggs, Administrator.
Union Hospital, Inc.
7th St. at 8th Ave., Terre Haute.

WABASH COUNTY

Mrs. E. A. Ford, Act. Administrator.
Wabash County Hospital.
670 N. East St., Wabash.

WARREN COUNTY

Mrs. Nellie O. Rudolph, Administrator.
The Community Hospital.
412 N. Monroe St., Williamsport.

WASHINGTON COUNTY

Mr. Frank Elrod, Administrator.
Washington County Memorial Hospital.
Salem.

WAYNE COUNTY

Mr. Frank G. Sheffler, Administrator.
Reid Memorial Hospital.
Spring Grove, Richmond.

J. Nelson Ewbank, M.D., Supt.
Smith Esteb Memorial Hospital.
R. R. No. 4, Liberty Pike, Richmond.

WELLS COUNTY

Mrs. Eileen Stipp, Administrator.
Clinic Hospital.
309 S. Main St., Bluffton.

Miss Clara Steiner, Supt.
Wells County Hospital.
1116 S. Main St., Bluffton.

WHITLEY COUNTY

Mr. Carl F. Arntson, Administrator.
Memorial Hospital.
215 E. Van Buren St., Columbia City.

Mr. Ralph E. Lyons, Administrator.
Whitley County Memorial Hospital.
353 N. Oak St., Columbia City.

ACCREDITED SCHOOLS OF NURSING

January, 1951

School of Nursing and Hospital, University or College with which School is connected	Location	Director, School of Nursing	Daily Patient Census
***St. John's	Anderson	Sister M. Celeste, R.N.	
Protestant Deaconess	Evansville	Miss Elsie Norman, R.N.	216
St. Mary's	Evansville	Sister Georgiana, R.N.	153
Welborn Memorial Baptist	Evansville	Mrs. Madeline T. Kinney, R.N.	98
aLutheran	Fort Wayne	Miss Myrtle Lewis, R.N.	216
Methodist	Fort Wayne	Miss Marie Kolter, R.N.	129
St. Joseph's	Fort Wayne	Sister M. Theodorita, R.N.	300
Methodist	Gary	Miss Mathilde Haga	224
St. Mary Mercy	Gary	Sister M. Vitalis, R.N.	219
xxxGoshen College	Goshen	Miss Orpah B. Mosemann, R.N., Actg.	
St. Margaret	Hammond	Sister M. Florianne, R.N.	242
Indiana University Training School for Nurses	Indianapolis	Miss Jean L. Coffey, R.N.	536
aIndianapolis General	Indianapolis	Miss Elizabeth C. Wivel, R.N.	576
Methodist	Indianapolis	Miss Fredericka Koch, R.N.	615
St. Vincent's	Indianapolis	Sister Clare, R.N.	365
***aGood Samaritan School-St. Joseph Memorial Hospital	Kokomo	Sister M. Bernadette, R.N.	141
Lafayette Home	Lafayette	Miss Lucille H. Johnson, R.N.	127
aSt. Elizabeth Division of St. Francis College	Lafayette	Sister M. Florina, R.N.	226
Ball Memorial	Muncie	Miss Clara May Miller, R.N.	246
aHoly Cross Central School	Notre Dame	Sister M. Amadeo, R.N.	
Hospital Units:			
St. John's Hospital	Anderson		
St. Joseph Hospital	South Bend		
St. Mary's Hospital	Cairo, Ill.		
Our Saviour's Hospital	Jacksonville, Ill.		
Good Samaritan School, St. Joseph Memorial Hospital	Kokomo		
xxxaSt. Mary's College	Notre Dame	Sister M. Amadeo, R.N.	
Reid Memorial	Richmond	Miss Prudence Appelman, R.N.	138
Memorial Hospital of South Bend	South Bend	Miss Clara Waln, R.N., Acting.	
***St. Joseph	South Bend	Sister M. Cecilian	
St. Anthony	Terre Haute	Sister Mary Nora, R.N.	159
Union	Terre Haute	Miss Emily Gifford, R.N.	174
Good Samaritan	Vincennes	Mrs. Zilpha Miller Burnett, R.N.	110

a Negro Students are enrolled.
*** Students admitted through Holy Cross Central School.
xxx Collegiate program.

LICENSED NURSING HOMES IN INDIANA

(As of May 15, 1951)

ADAMS COUNTY

Berne Nursing Home.
906 W. Main St., Berne.
Walter and Maxine Winchester, R.N.

ALLEN COUNTY

Colonial Nursing Home
802 W. Berry St., Fort Wayne
Miss Inez Gross, R.N.

Crater Nursing Home
1407 E. Wayne St., Fort Wayne
Mrs. Pearl Crater

"Crow's Haven"
2440 Bowser St., Fort Wayne
Mrs. Meta Crow

Grace Convalescent Home
1529 California Ave., Fort Wayne
Mrs. Jessie G. Richer

Lawton Nursing Home
1649 Spy Run Ave., Fort Wayne
Walter C. Buuck

Leslee Home
1161 W. Main St., Fort Wayne
Mrs. Lester Hollmann

Munson Home
336 Madison St., Fort Wayne
Mrs. Mabel Munson

Twin Maples Sanitarium
734 W. Washington Blvd., Fort Wayne
Mrs. Maude M. Cole

Yerrick Home for Men
516 W. Third St., Fort Wayne
Mrs. Gladys Yerrick

BARTHOLOMEW COUNTY

Brown Nursing Home
318 Smith St., Columbus
Mr. Ithamer Brown

Columbus Nursing Home
213 Fourth St., Columbus
Robert E. Lee

Redman's Sanitarium
R. R. 4, Columbus
Frank A. & Nellie D. Redman

BENTON COUNTY

Neal Nursing Home
3rd and Maple Sts., Earl Park
Mrs. Genevieve L. Neal

BLACKFORD COUNTY

Anderson Nursing Home
134 W. Green St., Montpelier
Mrs. Cora N. Anderson

Jackson Convalescent Home
434 S. Main St., Montpelier
Mr. Richard L. Jackson

BOONE COUNTY

Cora's Nursing Home
121-123 S. East St., Lebanon
Mrs. Cora Nelson

English Nursing Home
304 W. Washington St., Lebanon
Mrs. Bessie M. English

Trammel Nursing Home
415 N. Clark St., Lebanon
Mrs. Sarah S. Trammel

Davis Nursing Home
310 W. Main St., Thorntown
Mrs. Ruth Davis

Schwinn Nursing Home
214 S. Pearl St., Thorntown
Mrs. Pansy Schwinn

CARROLL COUNTY

Good Will Nursing Home
Corner Main & Monroe Sts., Camden
Miss Mabel E. Bechdolt

Porter Nursing Home
616 E. Monroe St., Delphi
Mrs. Alsie J. Porter

The Arzula Flora Nursing Home
312 W. Main St., Flora
Miss Ida Arzula Flora

Mamie Kennedy Nursing Home
404 S. Center St., Flora
Mrs. Mamie J. Kennedy

CASS COUNTY

Effie Bell Nursing Home
R. R. 2, West Jackson, Galveston
Mrs. Effie Bell

Galveston Nursing Home
Washington & Sycamore Sts., Galveston
Estie & Ednabelle Bell

Huffman Nursing Home
2533 E. Broadway, Logansport
Mrs. Honour Ruth Huffman

Justice Nursing Home
227 Cliff Drive, Logansport
Mr. and Mrs. Martin Justice

Rest Haven Nursing Home
731 North St., Logansport
Miss Olive S. Jones

Rose Lawn Home
3026 E. Broadway, Logansport
Miss Marie Wilsie Thomas

CLARK COUNTY

Jeffersonville Nursing Home
1315 N. Spring St., Jeffersonville
Mrs. Sara Roy

Keller Home
403 E. 7th St., Jeffersonville
Mrs. Florence Keller

CLAY COUNTY

Brazil Rest Home
525 E. Mechanic St., Brazil
Mrs. James Garvin

Dove Dell Rest Home
36 N. Forest St., Clay City
Mrs. Josephine Lowe

CLINTON COUNTY

Colfax Nursing Home
P.O. Box 826, Main St., Colfax
Mrs. Francis M. Waggoner

McKinsey Nursing Home
407 E. Walnut, Frankfort
Mrs. Jane McKinsey

Harriet Ann Stoker's Nursing Home
Rural Route 4, Frankfort
Mrs. Harriet Ann Stoker

DAVIESS COUNTY

Baker's Nursing Home
819 Axtell Ave., Washington
Mrs. Rose Ann Baker

Colvin's Nursing Home
1809 National Highway Washington
Mrs. Laura Colvin

Meyers Nursing Home
215 W. Oak St., Washington
Mrs. John Meyers

DECATUR COUNTY

The Black Nursing Home
619 W. Main St., Greensburg
Mrs. Pearl Black

Davis Nursing Home
510 W. Washington St., Greensburg
Mrs. Edith Davis

Michigan Hill Nursing Home
320 S. Michigan Ave., Greensburg
Mrs. Mary Clifton

Scripture Nursing Home
410 S. Broadway, Greensburg
Mrs. Urba M. Scripture

DEKALB COUNTY

Brouse Nursing Home
R.R. 2, Butler
W. H. & Susie M. Brouse

Williams Convalescent Home
402 N. Broadway, Butler
R. E. & Pauline Williams

Garrett Convalescent Home
611 S. Peters St., Garrett
Mr. and Mrs. Earle Saffen

DELAWARE COUNTY

Arlis Clark Nursing Home
South St., Eaton
Mrs. Arlis R. Clark

Morgan Convalescent Home
1408 E. Main St., Muncie
Mrs. Bernie B. Morgan, Jr., and
Mrs. Lucy Mae Morgan

Sylvester Home for the Aged
R.R. 5, Burlington Dr., Muncie
Mrs. Nellie V. Sylvester, R.N.

Williams Nursing Home
1525 S. Monroe St., Muncie
Mrs. Rena Williams

Woodland Home
917 E. Main St., Muncie
Mrs. Hazel Wilson

Karcher Home
Selma
Mrs. Aida Karcher

ELKHART COUNTY

Hope Convalescent Home
E. Vistula St., Bristol
Mrs. Bernice Alverson

The Herrli Home
318 E. Beardsley Ave., Elkhart
Mrs. Nellie M. Herrli

Cora Shaum Nursing Home
901 S. Second St., Elkhart
Mrs. Cora Shaum

The Austin Home
526 N. Sixth St., Goshen
Mr. and Mrs. Fred S. Austin

Coil Convalescent Home
225 S. Fifth St., Goshen
Mrs. Wilma L. Coil

Holm Convalescent Home
807 N. Main St., Goshen
Mrs. Goldie Holm Rogers

Lockerbie Nursing Home
302 E. Lincoln Ave., Goshen
Mrs. Bertha J. K. Lockerbie and
Jane Barnes

Weaver Convalescent Home
R. R. 5, Goshen
Mrs. Esther Weaver

FLOYD COUNTY

Culbertson Home
704 E. Main St., New Albany
Mrs. Virginia White

Griggs Nursing Home
710 E. Main St., New Albany
Mrs. Mary C. Griggs

FOUNTAIN COUNTY

Maplewood Nursing Home
R. R. 4, Veedersburg
Mrs. Mable Butte and
Mrs. Maxine Brown

FRANKLIN COUNTY

Brookside Nursing Home
R. R. 5, Brookville
Ida Ruth & Chester C. O'Neal

The Resthaven Reifel Nursing Home
1015 Franklin St., Brookville
Mrs. Elizabeth A. Reifel

FULTON COUNTY

McFarland Nursing Home
816 Jefferson St., Rochester
Mrs. Ralph McFarland

Rochester Nursing Home
719 Madison St., Rochester
Ernest Baxter

GIBSON COUNTY

Church Convalescent Home
417 W. Broadway, Princeton
Mrs. Edra E. Church

Hitch Convalescent Home
Patoka
Mrs. Ethel M. Hitch

GRANT COUNTY

Jackson Nursing Home
R. R. 2, Fairmount
Mrs. Maude J. Jackson

The Roberts Nursing Home
P.O. Box 102, Fowlerton
Mrs. Ethel Roberts

Darr's Convalescent Home
702 E. 26th St., Marion
Mrs. Maude L. Darr

Frances' Nursing Home
1827 South Adams St., Marion
Mrs. Frances Moore

Hills Nursing Home
1524 S. Washington St., Marion
Mrs. Josephine Hill

Mrs. Lanter's Home
1649 W. Second St., Marion
Mrs. Anna Lanter

HAMILTON COUNTY

Arcadia Rest Home
South School St., Arcadia
Mrs. Florence Sigler

Moore's Nursing Home
South St., Arcadia
Mrs. Anna Moore

Staton's Nursing Home
1071 Maple Ave., Noblesville
Mrs. Marjorie Staton

HANCOCK COUNTY

Siders Home
124 E. Osage St., Greenfield
Mrs. Elizabeth Siders

Wood's Nursing Home
14 N. Wood St., Greenfield
Mrs. Hazel E. Wood

Pleasant Acres
R. R. 12, Box 320, Indianapolis
Corner 56th & McCordsville Rd.
Frederick M. Burns

HENDRICKS COUNTY

Plainfield Nursing Home
404 Vine St., Plainfield
Miss Lois B. Thompson

HENRY COUNTY

Whitacre Nursing Home
Spiceland
Wm. H. & Margaret E. Whitacre

HOWARD COUNTY

Colonial Haven Nursing Home
613 E. Superior St., Kokomo
Mrs. Edith N. Tolle

Restmor Nursing Home
420 N. Market St., Kokomo
Mrs. Mary E. Devore

HUNTINGTON COUNTY

Davis Nursing Home
207 Frederick St., Huntington
Mrs. Annette Davis

DeKoning Convalescent Home
R. R. 8, Huntington
Mrs. Ann Cecilia DeKoning

Jefferson Sanitarium
414 S. Jefferson St., Huntington
Herbert Earl Atkinson, Sr.

Moore Home
425 Hasty St., Huntington
Mrs. Maud Moore

Sears Nursing Home
325 S. Jefferson, Huntington
Mrs. Ethel K. Sears

Oak Park Sanitarium
743 N. Main St., Roanoke
Mrs. Fern N. Martin

JACKSON COUNTY

Roselawn Home
202 W. 6th St., Seymour
Mrs. Esta T. Martin

JEFFERSON COUNTY

Madison Nursing Home
726 W. Main St., Madison
Mrs. Ella Shuell, R.N.

Glore Nursing Home
North Madison
Mrs. Flora Glore

Hilltop Rest Home
Box 67, North Madison
Mrs. Susan Obertate and
Mrs. Louise Obertate

JOHNSON COUNTY

Johnson Nursing Home
651 S. State St., Franklin
Mrs. Janie Johnson

McKee's Nursing Home
400 Kentucky St., Franklin
Mrs. Florence Ellen McKee

KNOX COUNTY

Moore's Nursing Home
203 W. Third St., Bicknell
Mrs. Adaline Bernice Moore

Compton Nursing Home
321 Hickman St., Vincennes
Mrs. Bertha C. Compton

KOSCIUSKO COUNTY

Alfran Nursing Home
R. R. 1, Road 30, Pierceton
Mrs. Alice M. Wilson, R.N.

Armington Home
519 W. Winona Ave., Warsaw
Mrs. Charles Armington

LAGRANGE COUNTY

Blick Convalescent Home
308-310 S. Detroit St., LaGrange
Mr. and Mrs. J. A. Blick

LAKE COUNTY

Hilltop Nursing Home
R. R. 2, Crown Point
Mrs. Olive Beggs

Shady Heights
Dyer
Mrs. Faye McGuire

Beaton's Nursing Home
521 Pennsylvania St., Gary
Mrs. Laura Beaton

Calloway's Nursing Home
1948 Massachusetts St., Gary
Mrs. Tomye D. Calloway

Greens Home
3960 Massachusetts St., Gary
Mrs. Lillian Green

Miller Nursing Home
2301 Adams St., Gary
Miss Ida Miller

Sanders Nursing Home
1944 Maryland St., Gary
Mrs. LaGora Sanders

West End Convalescent Home
1501 Wheeler St., Gary
Mrs. Esther G. Jones

Hodge Nursing Home
909 State St., Hammond
Mrs. Lana Hodge

LAWRENCE COUNTY

Kinder Nursing Home
618 "I" St., Bedford
Mrs. Mabel M. Kinder

Mrs. Estella Norwood Nursing Home
916 14th St., Bedford
Mrs. Estella Norwood

Stancombe Nursing Home
R. R. 5, Bedford
Clifford & Pearl Stancombe

The Greenwell Home
329 W. Oak St., Mitchell
Mrs. Florence Greenwell

MADISON COUNTY

Bright Memorial Home
2025 Jackson St., Anderson
Mrs. Blanche Graser

Goble Home
332 W. 11th St., Anderson
Mr. and Mrs. Oran Goble

McVey Nursing Home
1519 W. 3rd St., Anderson
Mrs. Stella May McVey

Pleasant Nursing Home
1719 Morton St., Anderson
Mrs. Alta V. Delph

Rahbek Nursing Home No. 1
1102 E. Sixth St., Anderson
Mrs. Marie L. Rahbek

Rahbek Nursing Home No. 2 (for women)
528 Walnut St., Anderson
Mrs. Marie L. Rahbek

Van Dyke Nursing Home
2417 Pearl St., Anderson
Mrs. Pearl M. Van Dyke

Hughes Nursing Home
1624 S. "M" St., Elwood
Mrs. Effie Hughes

McGuire Nursing Home
2224 S. "K" St., Elwood
Mrs. Nellie Fern McGuire

Rounds Nursing Home
1312 N. "D" St., Elwood
Mrs. Minnie Rounds

Scott's Nursing Home
339 Broadway, Pendleton
Mrs. Ruby Scott

MARION COUNTY

Tall Cedars
R. R. 1, Box 27, Bridgeport
Mrs. Ora Miley

Albrecht's Convalescent Home
2516 Central Ave., Indianapolis
Mrs. Gertrude Keller Albrecht, R.N.

Central Nursing Home
2262 Central Ave., Indianapolis
Mrs. Bertha A. Montgomery

Ethel Christen's Nursing Home
1930 Sugar Grove Ave., Indianapolis
Mrs. Ethel Christen

Conde Nursing Home
642 E. 12th St., Indianapolis
Marion Niles & Beulah Gronlund

Cottage Rest Home
46 S. Warman Ave., Indianapolis
Mrs. Louise Wooldridge

Ellis Nursing Home
2115 Central Ave., Indianapolis
Mrs. Mary Lou Ellis

Fletch-Haven Sanitarium
732 Fletcher Ave., Indianapolis
Martha L. & Garald Wayne Starr

Marie Fred Nursing Home
604 N. Jefferson Ave., Indianapolis
Mrs. Marie Fred, R.N.

Higgins Nursing Home
1336 Bellfontaine, Indianapolis
Mrs. Mollie Richardson

Hillside Nursing Home
2370 Hillside Ave., Indianapolis
Mrs. Ellen Mason

Hooper Nursing Home
1531 N. Capitol Ave., Indianapolis
Mrs. Carol Hooper

Huff Sanitarium
115 S. Audubon Rd., Indianapolis
Mrs. Rachel A. & Bettina Sullivan

Hulst Sanitorium
333 N. Delaware St., Indianapolis
Mrs. Mary E. Hulst

Irvington Sanitarium
R. R. 10, Box 320, Indianapolis
Mrs. Minnie P. Waymire

Jennings Rest Home
942 N. Alabama St., Indianapolis
Mrs. Etta B. Jennings

King Nursing Home
1907 N. Illinois St., Indianapolis
Mrs. Henrietta Princie King Quinn

Myrtle Lee Nursing Home
1429 Carrollton Ave., Indianapolis
Miss Mabel Cecilia Smalley

The Lou Wise
5170 W. Washington St., Indianapolis
Mrs. Bessie Craig

Lucile Nursing Home
610 N. Senate Ave., Indianapolis
Mrs. Lucile Mealure

Lynhurst Nursing Home No. 1
5225 W. Morris St., Indianapolis
Thomas E. & Barbaraella K. Brown

Lynhurst Nursing Home No. 2
6566 W. Washington St., Indianapolis
Mrs. Gladys Springer

Martin Nursing Home
1621 Park Ave., Indianapolis
Mrs. Lucille Martin

Matthews Rest Home
823 Broadway, Indianapolis
Mrs. Ethel M. Matthews

Maxson Nursing Home
842 Broadway, Indianapolis
Mrs. Helen Maxson

Messer Nursing Home
1336 N. Delaware St., Indianapolis
Mr. and Mrs. Calvin J. Messer

Mohler Sanatorium
702-704 N. Alabama St., Indianapolis
Mrs. Ada Anselm Mohler

Olympia Nursing Home
6879 E. Washington St., Indianapolis
Mrs. Frances Limpus

Pleasant View Rest Home
5000 Southeastern Ave., Indianapolis
Mrs. Laura E. Weber

Rest Haven Sanitarium
3245 N. Illinois St., Indianapolis
Mrs. Carolyn Carden

Robinson's Private Home #1
2254 Central Ave., Indianapolis
Mrs. Eunice C. Robinson

Robinson's Private Home #2
2250 Central Ave., Indianapolis
Mrs. Eunice C. Robinson

Rose Lawn Home
2835 N. Meridian St., Indianapolis
Mrs. Lucy V. Connor

Good Samaritan Sanitarium
2037 N. Illinois St., Indianapolis
Mrs. Olive Langdon and
Mrs. Alice Neal

Shady Rest Nursing Home
8643 E. Washington St., Indianapolis
Mr. Ralph E. Newby

Suddarth Nursing Home
1445 Broadway, Indianapolis
Mrs. Cleo Suddarth

Sunshine Nursing Home
4416 E. Washington St., Indianapolis
Mrs. Ethel M. Bills

Vollmer Convalescent Home
2630 College Ave., Indianapolis
Mr. Emory H. Vollmer

Mrs. Waddle's Private Home
2112 N. Delaware St., Indianapolis
Mrs. Mabel S. Waddle

Ward Nursing Home
1518 N. Senate Ave., Indianapolis
Mrs. Willa Mae Murray

Weber Convalescing Home
43 S. Ritter Ave., Indianapolis
Mrs. Laura E. Weber

West Park Home
373 N. Holmes Ave., Indianapolis
Mrs. Mary R. Frame

Wildwood Restorium
895 Middle Dr., Woodruff Pl., Indianapolis
Mrs. Nellie Wildman

MARSHALL COUNTY

Bair Convalescent Home
801 N. Main St., Bourbon
Mrs. Kathryn M. Bair

Austin Nursing Home
821 Angell St., Plymouth
Mrs. Mabel M. Austin

Pearl Street Nursing Home
618 Pearl St., Plymouth
Mrs. Bertha Mohr and
Miss Grace Stonehill

Sherman Nursing Home
203 Pennsylvania Ave., Plymouth
Mrs. Vesta K. Sherman

MIAMI COUNTY

Glen Rest Convalescent Home
R.R. #4, Peru
Mrs. Thelma Woeckener

Peru Nursing Home #1
906 W. Main St., Peru
Miss Marguerite Dillman and
Miss Helen Watson

MONROE COUNTY

DeKalb Nursing Home
532 N. College, Bloomington
Wilbur and Edna DeKalb

Hazel Nursing Home
1031 W. 6th St., Bloomington
Mr. William C. Hazel

Henry Home
421 W. First St., Bloomington
Mrs. Gertie Henry

Parrott Nursing Home
115 S. Lincoln St., Bloomington
Mary Gwendolia Parrott, R.N

Polley Nursing Home
705 W. 4th St., Bloomington
Mrs. Elsie Mae Polley

Wilkins Nursing Home #1
1023 E. 10th St., Bloomington
Mrs. Orpha A. Wilkins

Wilkins Nursing Home #2
601 N. Walnut Grove, Bloomington
Mrs. Orpha A. Wilkins

MONTGOMERY COUNTY

Hart Memorial Home
R. R. #1, Crawfordsville
Mrs. Myrtle Johnson

Maxwell Nursing Home
1805 E. Fremont St., Crawfordsville
Mrs. Godey Graves

Shahan Nursing Home
613 Kentucky St., Crawfordsville
Miss Eileen M. Shahan

Hazel Smalls Rest Home
N. Vine St., Waynetown
Mrs. Hazel Small

OHIO COUNTY

Galbreath Home
Fourth St., Rising Sun
Mrs. Effie Galbreath

OWEN COUNTY

Gosport Nursing Home
W. Main St., Gosport
Mrs. Mary Wampler

Jones Nursing Home
379 Hillside Ave., Spencer
Mr. and Mrs. Boyd Jones

Reapp Nursing Home
Greencastle Rd., Spencer
Mrs. Jennie C. Reapp

PARKE COUNTY

Wallace Nursing Home
517 W. Ohio St., Rockville
Mrs. Evelyn Wallace

PIKE COUNTY

Fay's Convalescent Home
210 S. 14th St., Petersburg
Mrs. Fay France

Riddle Nursing Home
411 Walnut St., Petersburg
Mrs. Alice M. Riddle

PORTER COUNTY

Wood Home
R. R. #2, W. Dunes Hwy., Michigan City
Mrs. Helen O. Wood

POSEY COUNTY

Allison Nursing Home
Locust St., Poseyville
Mrs. Lula Allison

PUTNAM COUNTY

Ruark Nursing Home
R. R. #1, Fillmore
Mrs. Elsie Cowgill Ruark

Craver Home
R. R. #3, Greencastle
Mrs. Hannah Craver

Westfall Nursing Home
128 Bloomington St., Greencastle
Mrs. Nina A. Westfall

RIPLEY COUNTY

Rick Nursing Home
R. R. #1, Milan
Mrs. Violet Rick

Gilland Nursing Home
310 Craven St., Osgood
Mr. and Mrs. Dan Gilland

Elsie Dreyer Nursing Home
Main St., Sunman
Miss Elsie Dreyer

RUSH COUNTY

Clark Nursing Home
230 E. 7th St., Rushville
Mrs. Harry Clark

Clifton Nursing Home #1
204 W. Third St., Rushville
Mrs. Mary Clifton

Clifton Nursing Home #2
R. R. #1, (Circleville), Rushville
Mrs. Mary Clifton

Jackson Nursing Home
114 E. Fifth St., Rushville
Mrs. Goldie C. Jackson

Rushville Nursing Home
321 N. Morgan St., Rushville
Mr. Jack Fordyce

SHELBY COUNTY

Foreman's Nursing Home
R. R. #1, Fountaintown
Mrs. Dorothy Foreman

Maples Convalescent Home
R. R. #1, Fountaintown
Mr. and Mrs. William McGraw

Lands Nursing Home
Morristown
Ida and Elbert Land

SPENCER COUNTY

Mayhall Nursing Home
417 S. 6th St., Rockport
Mrs. Alice R. Mayhall Freshley

ST. JOSEPH COUNTY

Copenhaver Home
914 W. 4th St., Mishawaka
Mrs. June Copenhaver

Emerick Home
910 W. 4th St., Mishawaka
Mrs. Ila Mae Emerick

Krogh Nursing Home
109 N. Cedar St., Mishawaka
Miss Bernalda I. Krogh

The Keiser Home
Box 102, North Liberty
Mrs. Mabel Keiser

Dor-A-Lin Convalescent Home
1024 N. Notre Dame Ave., South Bend
Mr. and Mrs. Franklin W. Finkenbinder

Frame's Nursing Home
1526 Lincoln Way, W., South Bend
Mrs. Myrtle Frame

Gibson Nursing Home
1145 Napier St., South Bend
Mrs. Ola Gibson

Vera Jones Nursing Home
702 S. Columbia St., South Bend
Mrs. Vera Jones

Kintz's Rest Home
1611 South Bend Ave., South Bend
Mrs. Edith Kintz

Williams Nursing Home #1
601 N. Main St., South Bend
Mrs. Alma Williams

Waldron Nursing Home
500 Roosevelt Rd., Walkerton
Mrs. Virginia Waldron

STARKE COUNTY

Ruff Nursing Home
75 W. John St., Knox
Mrs. Alcinda Ruff

STEUBEN COUNTY

Edith Nursing Home
116 N. Powers St., Angola
Mrs. Edith Schmidt

TIPPECANOE COUNTY

Laura M. Bowles Convalescent Home
Clarks Hill
Mrs. Laura M. Bowles

Burnett's
221 S. 9th St., Lafayette
Mrs. Angie Burnett

Lewis Nursing Home
641 New York St., Lafayette
Mrs. Betty Mackey Lewis

Scott Nursing Home for Men
614 N. 8th St., Lafayette
Mr. Howard F. Scott

Scott Nursing Home for Women
1100 N. 9th St., Lafayette
Mrs. Goldie Scott

TIPTON COUNTY

Simmons Nursing Home
325 N. West St., Tipton
Mrs. Ernest Simmons

UNION COUNTY

Scott Nursing Home
302 W. Union St., Liberty
Mrs. Anna Scott

VANDERBURGH COUNTY

Axton's Rest Home
203 Oakley St., Evansville
Mrs. Maymee M. Axton

Bethany Rest Home
316 N. Wabash Ave., Evansville
Mrs. Edith Poole Masterson

Comfort Rest Home
811 Southeast 3rd St., Evansville
Mrs. Ethel B. Drake

Evans Nursing Home
605 Oak St., Evansville
Mrs. Anna Evans

Floyd's Boarding Home
200-202 W. Illinois St., Evansville
Mrs. Laura Floyd

Fulton Rest Home
1328 N. Fulton Ave., Evansville
Mrs. Grace L. Richter

Gee's Rest Haven
807 Southeast 3rd St., Evansville
Mrs. Leona Gee

Gish's Rest Home
923 S. Elliott St., Evansville
Mrs. Ethel G. Gish

Jarrett Convalescent Home
605 Oakley St., Evansville
Mrs. Lena K. Jarrett

M & R Nursing Home
1100 N. Read St., Evansville
Mrs. Muriel A. Beumer

The Maxey Nursing Home
909 First Ave., Evansville
Mr. and Mrs. Pearless Maxey

Pleasant Nursing Home
109 W. Maryland St., Evansville
Mrs. Maryetta Morris

Ingle Smith Home
521 S.E. First St., Evansville
Mrs. Della Ingle Smith, R.N

Stinson Rest Home
315 S.E. Second St., Evansville
Mrs. Mildred Stinson

Taylor Nursing Home
915 W. Bond St., Evansville
Mrs. Juanita Taylor

Tindall Rest Home
216-218 Harriett St., Evansville
Mrs. Dorothy Wolf Tindall

Ulbricht Rest Home
516 W. Franklin St., Evansville
Mrs. Martha Ulbricht

VIGO COUNTY

Becker Nursing Home
736 Lafayette Ave., Terre Haute
Mrs. Lorena D. Becker

Cook Nursing Home
2058 N. 7th St., Terre Haute
Mrs. Grace E. Cook

Foos Nursing Home
418 S. 8th St., Terre Haute
Mrs. Lydia E. Foos

Gano Nursing Home
501 N. 4th St., Terre Haute
Mrs. Anna Gano

Hise Nursing Home
120 N. 12th St., Terre Haute
Mrs. Lillie Hise

Kesler's Nursing Home
724 N. 8th St., Terre Haute
Mrs. Clara A. Kesler

Mary Etta Nursing Home
1915 N. 11th St., Terre Haute
Mrs. Mamie Mason

Mrs. Barney Pigg Nursing Home
1334 Sycamore St., Terre Haute
Mrs. Barney Pigg

Rollo Boarding Home for Men
635 N. 6th St., Terre Haute
Mrs. Myrtle Rollo

Doris Standeford Nursing Home
1103 S. 11½ St., Terre Haute
Miss Doris Standeford

Meda Stevenson Home
905 Crawford St., Terre Haute
Mrs. Meda Stevenson

Sullivan Nursing Home
705 S. 7th St., Terre Haute
Mrs. Grace F. Sullivan

WABASH COUNTY

Sincroft Nursing Home
306 E. 4th St., North Manchester
Mrs. Pearl Sincroft

Moss Nursing Home
855 Ferry St., Wabash
Mrs. Irene Moss

WARRICK COUNTY

Hollis Nursing Home
R. R. #5, Boonville
Mrs. Loraine Hollis

WASHINGTON COUNTY

Shuell Nursing Home #1
R. R. #1, Scottsburg
Mrs. Ella L. Shuell, R.N

Shuell Nursing Home #2
R. R. #1, Scottsburg
Mrs. Ella L. Shuell, R.N

WAYNE COUNTY

Bowman's Rest Home
444 W. Main St., Cambridge City
Howard and Esther Bowman

Grey Gables Nursing Home
R. R. #1, Centerville
Mrs. Hazel C. Wadie

Pinehurst Nursing Home
R. R. #2, Centerville
Mrs. Gertrude E. Johnson

Gains Nursing Home #1
R. R. #2, Box 448, Richmond
Mrs. Emma Gains

Gains Nursing Home #2
R. R. #2, Richmond
Mrs. Emma Gains

Jennie Hartman Nursing Home
139 S.W. 14th St., Richmond
Mrs. Jennie Hartman

WELLS COUNTY

Davis Nursing Home
R. R. #3, Bluffton
Mr. Rolland W. Jackson

WHITLEY COUNTY

Farris Nursing Home
209 W. Market St., Columbia City
Mrs. Louise Farris

South Whitley Rest Home, Inc
Columbia St., South Whitley
Mr. and Mrs. Robert E. Bresnahan, and Grace Beaman

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Vocational Rehabilitation, the Family Physician in Relation to---------- 7, Jan. 1947
Welfare Acts, The Physician and the---- 14, Jan. 1947
Will, A Doctor Makes a---------- 563, July 1950
Workmen's Compensation Act ---------- 15, Jan. 1947

WARSAW TIMES-UNION
Warsaw, Indiana

May 23, 1951

Dr. Cleon A. Nafe
Chairman Indiana A.M.A.,
Coordinating Committee,
Indiana State Medical Assn.
Dear Sir:

This newspaper is in complete accord with the Indiana State Medical Association's staunch stand against anything which might lead our nation further towards socialized medicine or anything else in our government which reeks of socialism.

We, too, have joined many others in letting our congressmen know of our stand on this issue by personal contact, in direct letters and through our editorial columns. And we expect to continue this practice.

Copies of our personal letters to congressmen protesting socialized medicine legislation as well as future editorial comment will be submitted to your committee.

Kindest personal regards and best wishes,

Reub Williams.

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION‡

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's Principles of Ethics 1803.)

CHAPTER I

General Principles

CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATIONAL INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PATIENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

Duties of Physicians to Their Patients

STANDARDS, USEFULNESS, NONSECTARIANISM

SECTION 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is

‡ Adopted by the American Medical Association House of Delegates on June 6, 1949.

* Sir Thomas Watson.

* Nicon, father of Galen.

a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

CHAPTER III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLDING THE HONOR OF THE PROFESSION

SECTION 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

DEPENDENCE OF PHYSICIANS ON EACH OTHER

SECTION 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

ARTICLE III.—DUTIES OF PHYSICIANS IN CONSULTATIONS

CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

SEC. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

SEC. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made, nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

SEC. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is

privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the phyisician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS

ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promplty adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SECTON 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Frec choice of physician is defined as that degree of frecdom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether

the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC

PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

CONSTITUTION AND BY-LAWS OF THE INDIANA STATE MEDICAL ASSOCIATION*

CONSTITUTION

ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II.—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

* Adopted by the House of Delegates at Indianapolis, September 29, 1949.

ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

Sec. 2.—*Active Members.*—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant membership therein on a basis that does not include membership in the Indiana State Medical Association.

Sec. 3.—*Associate Members.*—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 4—*Senior Members.*—Senior members shall be physicians of the State of Indiana who have attained the age of seventy-five years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by the county societies of which they are members.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above

qualifications, shall hereafter be classified as senior members.

Sec. 5.—*Honorary Members.*—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Sec. 6.—*Rights and Privileges of Members.*—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex-officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer. Besides its duties mentioned in the By-Laws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the By-Laws, and at all times shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

ARTICLE VIII.—CONVENTION AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Sec. 2.—The House of Delegates shall select the place two years in advance for holding the annual convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTICLE IX.—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. All of these officers shall serve until their successors are elected and installed. Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with Section 4 of this article.

Sec. 3.—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.

2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.

3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII.—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

BY-LAWS

CHAPTER I.—MEMBERSHIP

Section 1.—The term "Member" as used in these By-Laws unless otherwise indicated shall mean both active and senior members. Provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association.

Sec. 3.—No person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President shall be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Committee on Scientific Work, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for each Annual Convention, for the entertainment of its members and guests, such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such convention. The entertainment funds so appropriated shall be expended at the direction of the Committee on Convention Arrangements, appointed by the President for the convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the State Association.

CHAPTER III.—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

a. Surgical.

b. Medical.

c. Eye, Ear, Nose, and Throat.

d. Anesthesia.

e. General Practice.

f. Obstetrics and Gynecology.

g. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV.—HOUSE OF DELEGATES

Section 1.—The House of Delegates shall meet the day before or during that fixed as the first day of the scientific meeting of the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and By-Laws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate to be selected by the physicians residing in such county.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before August first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in

accordance with the Constitution and By-Laws of that body.

b. Divide the State into Councilor Districts, specifiying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5. — Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4.—The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The President, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and Journal offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expense of attending the Annual Convention.

CHAPTER VII.—COUNCIL

Section. 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates

and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates.

Sec. 2. — Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall elect two members of the Association, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee.

CHAPTER VIII.—STANDING COMMITTEES

Section 1.—The standing committees shall be as follows:

The Executive Committee.

A Committee on Convention Arrangements.

A Committee on Scientific Work.
A Committee on Scientific Exhibits.
A Committee on Public Policy and Legislation.
A Committee on Publicity.
A Committee on Industrial Health.
A Committee on Medical Education and Hospitals.
A Committee on Public Relations.
A Committee on Constitution and By-Laws.

Such committees, except the Executive Committee, which is elected by the Council, shall be appointed by the President of the Association.

All members of committees shall serve for one year unless otherwise specified in these By-Laws or in the authorization for appointment.

Sec. 2.—*The Executive Committee,* consisting of six members as heretofore provided for, shall meet on the call of the Chairman or of any three members with the Executive Secretary to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall constitute the Medical Defense Committee of the Association and shall have full authority governing all matters pertaining to the medical defense features of this Association, and shall be governed by the rules and regulations concerning such features as provided for in the By-Laws of this Association. It shall represent the Council during the intervals between meetings of that body, including matters pertaining to THE JOURNAL of the Association, and shall report its doings to the Council.

It shall prepare a budget for the ensuing calendar year; and all expenditures of the Association, except those otherwise provided for under the Constitution and By-Laws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and By-Laws shall be incurred by any officer or committee. A committee or an officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Sec. 3.—*The Committee on Convention Arrangements* shall consist of five or more members. With the advice and assistance of the Executive Secretary this committee shall provide suitable accommodations for the meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements for and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 4.—*The Committee on Scientific Work* shall consist of three or more appointive members appointed by the President; and of the chairman of the Committee on Scientific Exhibits and of the chairmen of the sections as *ex officio* members. It shall be the duty of the officers of the various sections to prepare and submit to this committee prior to the first meeting of the committee a suggested program of subjects and personnel for their respective section programs for the Annual Convention. The scientific program and the financial requirements to provide for it must be approved by the Executive Committee before the program is officially announced.

Sec. 5.—*The Committee on Scientific Exhibits* shall consist of five or more appointive members. It shall have the duty of arranging for scientific exhibits as a part of the Annual Convention, subject to the approval of the Executive Committee.

Sec. 6.—*The Committee on Public Policy and Legislation* shall consist of at least five or more appointive members. Under direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of public health, medical education, scientific medicine, and the improvement of the medical profession. It shall keep in touch with professional and public opinion and shall endeavor to create and direct public opinion to the end that the public will demand adequate legislation for the promotion of the public good in relation to medicine and the enforcement of such legislation.

Sec. 7.—*The Committee on Publicity* shall consist of three appointive members. It shall be responsible for the dissemination of information concerning individual and community health to the lay public through articles prepared for publication in lay publications, and for addresses or talks delivered before lay audiences under the authority of the Association, and shall in every way seek to give the lay public a better knowledge and understanding of the aims and objects of scientific medicine.

Sec. 8.—*The Committee on Industrial Health* shall consist of five or more appointive members. The duties of the committee shall be: To study and gather facts and become intimately acquainted with the problems regarding industrial health, including any such problems as those relating to the prevention and cure of industrial injuries and diseases; to study the method and means of providing adequate medical and hospital care for those suffering from industrial diseases and injuries; and to encourage cooperation and mutual understanding among the members of the medical profession, employers of labor, employees and insurance carriers.

Sec. 9.—*The Committee on Medical Education and Hospitals* shall consist of five appointive members. The duties of this committee shall be

to cooperate with the authorities of the Indiana University School of Medicine in efforts to improve the educational standards of the state as they pertain to the practice of medicine; to act in conjunction with the members of the Council in providing postgraduate clinics or teaching for the various Councilor medical districts of the state; to cooperate with the Hospital Council of the Indiana State Board of Health in connection with the making and recommending of rules and regulations for the management of hospitals; to select one of its own members as a delegate to the yearly Conference on Medical Education and Hospitals of the American Medical Association; and to cooperate with the corresponding Council of the American Medical Association.

Sec. 10.—*The Committee on Public Relations* shall consist of five or more appointive members. The duties of the committee shall be to develop and carry on continuously a program to improve and sustain good will among the members of the medical profession and the general public; to study and assemble information regarding the means by which the interests of the public relations of the medical profession may best be served; to obtain through public and professional contacts and report to the profession through proper means information regarding the sentiments, criticism and suggestions for improvement which may be made either by members of the profession or by the lay public; and to have the special responsibility of furnishing leadership and guidance in keeping the medical profession as a whole within the deserved respect and esteem of the people.

Sec. 11.—*The Committee on Constitution and By-Laws* shall consist of five appointive members. The duties of this committee shall be: to keep in contact with the developments and changes in procedures in carrying on the work of this Association; to suggest revisions necessary to keep the Constitution and By-Laws always in accord with the practices and procedures best adapted to the functioning of the Association; and to keep the practices and procedures consistent with the provisions from time to time contained in the Constitution and By-Laws—to the end that all members of the profession, by reference to the Constitution and By-Laws, may be able to obtain accurate information regarding procedure and practices within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and By-Laws may be avoided.

Sec. 12.—The President and Executive Secretary shall be *ex officio* members of all the foregoing standing Committees where their inclusion on the committee is not otherwise provided for in these By-Laws.

CHAPTER IX.—SPECIAL COMMITTEES

The President may appoint such other committees in addition to the standing committees as he deems necessary or as may be specially authorized by the House of Delegates, the Council, or the Executive Committee. Any such committees shall be known as special committees.

CHAPTER X.—REFERENCE COMMITTEES

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, the chairman to be specified by the President. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2.—The following reference committees are hereby constituted:

(1) A Committee on Sections and Section Work to which shall be referred all matters relating to the sections or section work.

(2) A Committee on Rules and Order of Business to which shall be referred all matters regarding rules governing the action, methods of procedure, and order of business of the House of Delegates.

(3) A Committee on Medical Education and Hospitals to which shall be referred all matters relating to medical education and medical colleges and hospitals.

(4) A Committee on Public Policy and Legislation to which shall be referred all matters relating to state and national legislation, and memorials to the legislature, to the United States Congress, to the Governor of the State, or to the President of the United States.

(5) A Committee on Publicity to which shall be referred all matters relating to publicity.

(6) A Committee on Hygiene and Public Health to which shall be referred all matters relating to hygiene and public health.

(7) A Committee on Amendments to the Constitution and By-Laws to which shall be referred all proposed amendments to the Constitution and By-Laws.

(8) A Committee on Reports of Officers to which shall be referred the address of the President and the reports of the Executive Secretary, Treasurer, and the Council.

(9) A Committee on Credentials to which shall be referred all questions regarding registration and the credentials of delegates.

(10) A Committee on Miscellaneous Business to which shall be referred all business not otherwise disposed of.

Sec. 3.—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

CHAPTER XI.—COUNTY SOCIETIES

Section 1.—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, on application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and By-Laws and other rules and resolutions of this Association.

Sec. 2.—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Sec. 3.—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4.—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Sec. 5.—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6.—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7.—When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before August first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of

the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be the calendar year, and all dues shall be for the year and *payable in advance.* The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members. The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay $10.00 as dues for the remainder of that year. Interns and residents shall pay $10.00 a year annual dues during their term of service in the hospital. In the event the county society remits a member's dues for good cause, and the secretary of the county medical society recommends in writing the remission of the state association dues of said member of the society, and shows good cause why such recommendation should be granted, the Council shall have the power to remit such dues.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and By-Laws, not in conflict with the Constitution and By-Laws either of this Association or of the American Medical Association, a copy of which shall be filed with the Executive Secretary of this Association; and furthermore, the Executive Secretary shall be notified at once of any changes or amendments that may be made from time to time.

CHAPTER XII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XIII.—MEDICAL DEFENSE

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This committee shall have full authority governing all matters pertaining to the medical defense features of this Association; with power to enter into agreement for the payment of fees of one attorney whom the physician sued shall have the right to choose, provided such attorney is of good reputation and standing at the bar, and to employ expert witnesses and incur such other expenses as in the judgment of the committee may be necessary in the defense of members against whom suits may be brought; provided, always, that the total expenditure in any single suit shall not exceed 25 per cent of the fund available at the time suit is filed; and provided further that this Association shall not be liable for attorney's fees in such suits unless this committee shall have first agreed in each case with the physician sued and the attorneys representing him in regard to the terms of such employment, including the fees to be paid.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these By-Laws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues

for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these By-Laws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

CHAPTER XIV.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XV.—AMENDMENTS

Section 1.—These By-Laws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and By-Laws all previous Constitutions and By-Laws are hereby repealed.

MARTINSVILLE DAILY REPORTER
Martinsville, Indiana

May 26, 1951

Clean A. Nafe, M.D., Chairman
Indiana A.M.A. Coordinating Committee
Indiana State Medical Association
Dear Dr. Nafe:

I believe more and more people are coming to realize what will happen if we yield to Washington power to control our daily lives. It is gratifying that American physicians are using the medium of newspaper advertising to help get the message of freedom to the people.

Plots against our liberties must be exposed!

I hope soon to be able to make appropriate editorial comment on the Ewing schemes.

Sincerely,
Robert S. Kendall

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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DOCTORS FOR THE ARMED SERVICES

AN INTERIM REPORT made recently by the Committee on Military Manpower indicates that the commissioning of doctors in Indiana is progressing smoothly and satisfactorily.

The recent requisition by the Armed Forces on Selective Service for 1202 M.D.'s during the next several months indicates that the classification of registrants in Priorities I and II under the Doctors' Draft Law is now completed and an induction date will soon be set for those doctors who are in Priority I and the lowest age group.

To date, volunteers have filled all the quotas and it is hoped the actual drafting of physicians will not take place.

Applicants for commissions who have been passed as physically acceptable to the Army are being processed to meet the immediate monthly call for physicians. The number called to active duty each month has not been sufficient to interfere with effective medical care in the state.

In Priority I approximately 50 percent have requested commissions. In this priority rejections for physical reasons have amounted to 20 percent and about 15 percent have been deferred, either as essential to the health and welfare of their communities or for the purpose of finishing the current year of internship or residency. Those deferred during hospital training will be reviewed for extension of deferment or reclassification. Under Selective Service no classification is permanent and deferments are granted for three, six, nine or twelve month periods with re-evaluation of essentiality from time to time.

After all registrants in Priority I have been processed, Priority II, which is the smaller group, will be offered commissions. It is estimated that the rate of deferrals and rejections for physical reasons will be the same as for Priority I.

The Army is now completing a re-evaluation of all its reserve officers. After the review of all medical reserve officers on professional and physical considerations is finished, the Manpower Committee will classify them as to essentiality and priority.

The medical profession and the citizens of Indiana may be proud of the manner in which our military medical obligations have been fulfilled. It is reported that the Selective Service Boards have been most cooperative. Complaints and criticism of the system have been minimal.

The committee has now completed an information file on all physicians in Indiana. Its objective is to provide doctors for the Armed Services, and to do so without disrupting the medical care of the civilian population.

NEED OF CHANGE IN UNDERGRADUATE MEDICAL CURRICULUM

THERE appears to be a widely held conviction that for some reason the public has not benefited from the great advances of scientific medicine in recent years. To find that this is true, one has only to listen to the complaints of substantial and fair minded men, that they have difficulty in getting the kind of day-to-day medical service which they desire.

Substantial sections of the public believe that the kind of medical service they want and can't get now can be obtained by a system of compulsory health insurance. Fortunately the hard core of American character is still intact and constitutes a base for opposition to the encroachment of government on the liberties of its citizens.

Plutarch, commenting on the causes of the fall of the Roman Republic, had this to say: "For it has been well and truly said that the first destroyer of the liberties of a people is he who first gave them bounties. At Rome the mischief seems to have stolen secretly in, and by little and little, not being at once discovered and taken notice of."

It can be said that there is no secret about the bounties and subsidies which have been granted by our government, avid for continued power. The only secret about it is the effect of such bounties on the political morality of the citizenship of the country. An unbroken historical record of disaster for all governments following such a pattern would seem to be enough to cause us to halt.

The medical profession finds itself in a vulnerable position in the social and political struggle now appealing for popular support. The leaders in the profession have begun to ask some very searching questions of their own record in attempting to locate, if possible, any cracks in the structure of public confidence built up from years of faithful service to the sick.

An increasingly large number of responsible leaders in the profession have been casting a critical eye on the undergraduate curriculum as the prime source of many of the problems that have arisen to plague the organized profession in its relation to the public.

In 1910 Abraham Flexner, financed by the Carnegie Foundation, made his epochal report on Medical Education in the United States and started a revolution in this field which, before it ended, had closed hundreds of so-called medical schools and laid the foundation for a totally new conception of scientific medicine. Aided by university connections the new curriculum was based on the laboratory, with all its possibilities for scientific precision. Clinical medicine was gradually by-passed, and the student has all but forgotten that some place in the picture there is a sick patient.

At the present time undergraduate medical education is conducted under the leadership of full time professors in department straight jackets. The head of the department may be and often is a Nobel prize winner, but that he has any responsibility in integrating his subject with the problems involved in caring for a sick patient seems unlikely.

It is an ironical fact that the very principles that underlie the modern undergraduate curriculum, while so valuable in rescuing medical education from mediocrity and worse, have been the cause of precipitating some of the most serious medical problems of today. As someone has truly said, "The Flexner ideal of a curriculum based upon predominance of the laboratory subjects is today suffering from the defects of its own virtue." That there is ample evidence that these defects are being recognized and steps taken to correct them, attention is called to the 1950 32nd Annual Report of the Commonwealth Fund. This fund is a philanthropic endowment founded by the Harkness family, Chicago University founder. The report shows that $5,000,000 was voted in 1950 for medical research and education. The Board of Directors makes the following statement of principles which guided them in allocating this amount to the subject of medical education. "The laboratory sciences now stand too much alone. Their relation to clinical judgment is often left unclear in the student's mind. A good many young physicians have been taught to rely so confidently on laboratory diagnosis that when this fails there is nothing left to do for the patient.

"As for the control of clinical material by the medical school, that has gone so far that it is hard to get a broad clinical experience in the teaching hospital, where the specialists, who have come to dominate medical education, find it easy to stress the rare disease rather than the common one, and the student may lose touch with many everyday problems of medical care."

Within the past year the Fund has made appropriations of $269,400 (with reservation of an additional $164,000) to Western Reserve School of Medicine to aid it in working out and putting into effect, during the next five years, methods of rebuilding the entire medical curriculum, the objective being to bring into better balance the laboratory and clinical teaching.

Murray N. Hadley, M.D., Indianapolis

BLUE SHIELD

MUTUAL MEDICAL INSURANCE, INC., the Blue Shield plan for Indiana, has now come of age. A 48 percent increase in membership in 1950 has brought a grand total of more than half a million people under its protection. It is now seventh in size among all the nonprofit medical plans in the United States.

Acceptance of Mutual Medical was prompt when it was organized a little less than five years ago. Its growth and development since then have been vigorous and steady.

Group and community enrollments and the establishment of a variety of medical and surgical plans have broadened its sphere of activity and have brought its benefits within the reach of more and more of our citizens. Liberalization of benefits has been made possible because of economical administration and favorable utilization experience.

With the increase in membership and more comprehensive medical plans the number of physicians who receive payments has increased markedly. During the past year payments were made on behalf of its members to 2,744 doctors. Since its inception Mutual Medical has paid slightly more than five million dollars in claims; approximately half of this total was disbursed in 1950.

The amount of income which is devoted to administrative expenses is one of the best indexes of the soundness and efficiency of such a system. The lower the expenses, the more money can be applied to the medical expenses of the members. Mutual Medical now has an administrative cost in the neighborhood of 12 percent, a figure which is considered well within reason for a young, expanding plan.

The percentage of the state's population covered by the plan at the end of 1950 was 13.7. This is slightly in excess of the 12.2 percentage for the country as a whole (44 states and the District of Columbia). However, there are many people in Indiana who are not covered by Blue Shield, nor by any medical care plan.

One of our best defenses against the socialization of medicine is the orderly development of voluntary medical insurance. The medical profession may take great pride in the growth of Blue Shield. The profession should now continue to take an interest in the expansion of all types of sound voluntary insurance. Each satisfied owner of a well managed medical insurance policy is one less possible advocate of socialization.

PRIZE ESSAY AWARDS

The editors of the *Journal* take pleasure in announcing that the third annual prize essay contest for fourth-year medical students has been won by John A. Meyer, a senior student at Western Reserve University School of Medicine. Mr. Meyer's report and discussion of a case of "Coarctation of the Aorta," which was awarded the first prize of $100, will be published in a subsequent issue.

Robert R. Simpson, a member of the fourth-year class at Indiana University School of Medicine, has been awarded the second prize, a two-year subscription to the *Journal*. The title of his report was "A Study of Aneurysm of the Thoracic Aorta."

The competition this year was based on the report of a case that the student had personally studied, with a discussion and review of the subject. This has proved to be the most popular assignment so far, and the number of competitors was nearly double that of the preceding year. The same subject will be assigned for the 1952 contest—a case personally studied by the student, with a discussion and review of the literature—manuscripts to be in the hands of the editor by March 15, 1952.

It is not necessary to dwell on the satisfaction that the editors derive from the student interest in the *Journal*. Recent mention has been made of the fact that on March 22 the number of student subscribers reached 5,000, and has now gone somewhat beyond that figure.—*New England Journal of Medicine*, May 17, 1951.

Believe It Or Not—

From Kansas City we glean the following commentary on the adaptability of young medicos, *before* being subjected to too much military indoctrination (*Jackson County Medical Society Weekly Bulletin*):

One of the biggest scoops to come out of the Korean "police action" has been the efficiency of the unindoctrinated medical personnel. The Pentagon planners still can't believe their eyes and ears, but the facts are indisputable.

It seems that around one hundred medical men, with no previous military experience, were flown to Korea. They were sent to the fighting front fresh from their residencies. Of course, they were commanded by experienced, field-trained, medical officers. Results: A fatality ratio of casualties one-fourth that of World War II!

One of the surgical residents from the Kansas City General Hospital was in Korea exactly eight days from the time he left Kansas City.

What! No Carlisle Barracks?

Membership Roster

INDIANA STATE MEDICAL ASSOCIATION

Following is a list of members of the Indiana State Medical Association as of December 31, 1950, plus those who have become members between December 31, 1950 and June 1, 1951.

The letter (H) following a name indicates that the physician is an honorary member of his local society and of the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1017 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

ALPHABETICAL LIST OF MEMBERS

A

Name	City	County
Aagesen, J. W.	Anderson	Madison
Abel, J. A.	South Bend	St. Joseph
Abell, Charles F.	Marion	Grant
Abreu, Benedict E.	Indianapolis	Marion
Acher, Robert P.	Greensburg	Decatur
Acker, Robert B.	South Bend	St. Joseph
Acos, James C.	East Chicago	Lake
Acre, R. R.	Evansville	Vanderburgh
Adair, Samuel L.	Jeffersonville	Clark
Adair, Wm. K.	Crothersville	Jackson
Adams, Charles J.	Kokomo	Howard
Adams, Max R.	Flora	Carroll
Adams, William B.	Muncie	Delaware-Blackford
Adamski, Michael S.	Logansport	Cass
Ade, C. H.	Lafayette	Tippecanoe
Ade, Mary	Lafayette	Tippecanoe
Adkins, H. C.	Indianapolis	Marion
Adkins, Onan C.	Indianapolis	Marion
Adler, David L.	Columbus	Bartholomew-Brown
Adler, Edmund R.	Dyer	Lake
Adler, Raymond N.	Evansville	Vanderburgh
Adney, Frank B., Jr.	Richmond	Wayne-Union
Agee, Ernest B., Jr.	Terre Haute	Vigo
Aiken, Arthur F.	Ft. Wayne	Allen
Aiken, Milo M.	Plainfield	Hendricks
Aiken, N. E.	Ft. Wayne	Allen
Ake, Loren	Richmond	Wayne-Union
Albertson, F. P.	Indianapolis	Marion
Alderfer, Henry	Marion	Grant
Aldrich, Harry	Indianapolis	Marion
Aldrich, Howard	Indianapolis	Marion
Aldridge, J. W.	Covington	Fountain-Warren
Alexander, Ezra D.	Indianapolis	Marion
Alexander, H. H.	Princeton	Gibson
Alexander, J. E.	Evansville	Vanderburgh
Alexander, O. O.	Terre Haute	Vigo
Alexander, P. M.	Martinsville	Morgan
Alexander, Stephen J.	Crawfordsville	Montgomery
Alford, James	Hamilton	Steuben
Allegretti, Michael	Hammond	Lake
Allen, Fred K.	New Albany	Floyd
Allen, Hubert E.	Richmond	Wayne-Union
Allen, J. L. (H)	Greenfield	Hancock
Allen, L. Howard	Bedford	Lawrence
Allen, Orris T.	Terre Haute	Vigo
Allen, Robert K.	Indianapolis	Marion
Allen, Robert T.	Richmond	Wayne-Union
Almquist, C. O.	Gary	Lake
Altier, W. H.	Fowler	Benton
Alvey, Charles R.	Muncie	Delaware-Blackford
Alvis, Edmond O.	Indianapolis	Marion
Alward, John Haney	Kokomo	Howard
Ambrose, J. C.	Noblesville	Hamilton
Ames, George (H)	Eaton	Delaware-Blackford
Amick, Charles L.	Wakarusa	Elkhart
Amos, R. L.	New Castle	Henry
Amstutz, Henry C.	Goshen	Elkhart
Amy, W. E.	Corydon	Harrison
Anderson, Dwight	Evansville	Vanderburgh
Anderson, R. M.	Vincennes	Knox
Anderson, Walter C.	Terre Haute	Vigo
Anderson, Wendell C.	Indianapolis	Marion
Annis, Homer B.	Bluffton	Wells
Antes, Earl H.	Evansville	Vanderburgh
Appel, Richard H.	Indianapolis	Marion
Applegate, Albert E.	Frankfort	Clinton
Arbeiter, Herbert I.	Hammond	Lake
Arbogast, J. L.	Indianapolis	Marion
Arbogast, Paul B.	Vincennes	Knox
Arbuckle, Russell	Indianapolis	Marion
Arbuckle, Wm. E.	Indianapolis	Marion
Arisman, R. K.	South Bend	St. Joseph
Arlook, Theodore D.	Elkhart	Elkhart
Armington, C. L.	Anderson	Madison
Armington, John C.	Anderson	Madison
Armington, Robert	Anderson	Madison
Armstrong, T. D.	Michigan City	La Porte
Arnett, A. C.	Lafayette	Tippecanoe
Arnold, Aaron L.	Indianapolis	Marion
Arnold, M. F.	East Chicago	Lake
Arnold, Robert D.	Indianapolis	Marion
Aronson, Sidney S.	Indianapolis	Marion
Arrowsmith, James L.	Hammond	Lake
Arthur, H. M. (H)	Hazelton	Gibson
Asbury, W. D. (H)	Terre Haute	Vigo
Ash, H. H.	W. Lafayette	Tippecanoe
Asher, E. O.	New Augusta	Marion
Asher, James W.	New Augusta	Marion
Ashworth, L. N.	Connersville	Fayette-Franklin
Atchison, Kenneth C.	Rockport	Spencer

Name	City	County
Atkins, C. C.	Rushville	Rush
Atkinson, C. W.	Boswell	Benton
Aucreman, C. J.	Bluffton	Wells
Ault, Roy, Jr.	Terre Haute	Vigo
Austin, Charles E.	Anderson	Madison
Austin, Eugene W.	Evansville	Vanderburgh
Austin, F. H. (H)	Bloomington	Owen-Monroe
Austin, M. A. (H)	Anderson	Madison
Austin, R. P.	Bedford	Lawrence
Ayres, Kenneth D.	Anderson	Madison
Ayres, W. W.	Marion	Grant
B		
Babb, Forrest J.	Stockwell	Tippecanoe
Bachmann, Arnold J.	Indianapolis	Marion
Backer, Henry G.	Ferdinand	Dubois
Badders, A. C.	Portland	Jay
Bahr, Max A. (H)	Indianapolis	Marion
Bailey, Edwin B.	Linton	Greene
Bailey, E. W.	Logansport	Cass
Bailey, L. S.	Zionsville	Boone
Bailey, Paul P.	Fort Wayne	Allen
Bailey, Wm. A. (H)	Vincennes	Knox
Baitinger, H. M.	Gary	Lake
Bakemeier, O. H.	Indianapolis	Marion
Baker, A. M.	New Albany	Floyd
Baker, G. D.	Crandall	Harrison
Baker, Herman	Evansville	Vanderburgh
Baker, J. S.	Evansville	Vanderburgh
Baker, Leslie M.	Aurora	Dearborn-Ohio
Baker, Milan	Culver	Marshall
Baker, Robert E. (H)	Orleans	Orange
Baker, Warren	Michigan City	LaPorte
Balch, James F.	Indianapolis	Marion
Baldridge, W. O.	Terre Haute	Vigo
Baldwin, J. H.	Jeffersonville	Clark
Balkema, Cath. M.	Lafayette	Tippecanoe
Balkin, Ruth B.	Gary	Lake
Ball, Clay A.	Muncie	Delaware-Blackford
Ball, Joseph E.	Indianapolis	Marion
Ball, T. Z. (H)	Crawfordsville	Montgomery
Balla, Morris	South Bend	St. Joseph
Ballard, C. A.	Logansport	Cass
Ballard, John E.	Muncie	Delaware-Blackford
Ballard, Robert J.	Lebanon	Boone
Ballas, William A.	Evansville	Vanderburgh
Ballenger, W. E.	Richmond	Wayne-Union
Balsbaugh, George	N. Manchester	Wabash
Baltes, Joseph H.	Fort Wayne	Allen
Banister, R. F.	Indianapolis	Marion
Banker, Harry W.	Bluffton	Wells
Bankoff, Milton L.	Michigan City	LaPorte
Banks, H. M.	Indianapolis	Marion
Baran, Charles	South Bend	St. Joseph
Barclay, I. C.	Evansville	Vanderburgh
Bard, Frank B.	Crothersville	Jackson
Barnes, Helen B.	Greenwood	Johnson
Barnett, R. E.	Peru	Miami
Barnhart, Willard T.	Evansville	Vanderburgh
Barnum, Edwin N.	Indianapolis	Marion
Barnum, Emerson	Shelbyville	Shelby
Barone, Carmelo V.	Mishawaka	St. Joseph
Barrett, D. C.	Indianapolis	Marion
Barron, Elmer A.	East Chicago	Lake
Barrow, John H.	Dale	Spencer
Barry, M. J.	Indianapolis	Marion
Barry, Maurice J., Jr.	Rochester, Minn.	Marion
Bartholomew, A. C.	Fort Wayne	Allen
Bartholomew, Mary	Goshen	Elkhart
Bartle, J. Leo	Indianapolis	Marion
Bartley, Max D.	Indianapolis	Marion
Barton, Robert	Angola	Steuben
Barton, W. M.	Centerville	Wayne-Union
Bartsch, Harvey L.	South Bend	St. Joseph
Bash, Wallace E.	Fort Wayne	Allen
Baskett, R. J.	Jonesboro	Grant
Bassett, Clancy	Thorntown	Boone
Bassett, Margaret	Thorntown	Boone
Bassler, C. R.	Mishawaka	St. Joseph
Batman, Gordon W.	Indianapolis	Marion
Battersby, J. Stanley	Indianapolis	Marion
Batties, Paul A.	Indianapolis	Marion
Bauer, A. J.	Lafayette	Tippecanoe
Bauer, Thomas B.	Indianapolis	Marion
Baughn, William L.	Anderson	Madison
Baum, Harry	Indianapolis	Marion
Baumeister, Herbert E.	Indianapolis	Marion
Baumgartner, Jeraldine	Fort Wayne	Allen
Baxter, J. W., Jr.	New Albany	Floyd
Baxter, Neal	Bloomington	Owen-Monroe
Baxter, Samuel M.	New Albany	Floyd
Bayley, William E.	Lafayette	Tippecanoe
Baylor, Edward M.	Evansville	Vanderburgh
Beach, Robert R.	Indianapolis	Marion
Beam, Vernon B.	East Chicago	Lake
Beams, Ralph H.	Fort Wayne	Allen
Bean, Joseph S.	Indianapolis	Marion
Bear, L. H. (H)	Vevay	Switzerland
Beardsley, Frank A.	Frankfort	Clinton
Beardsley, John	Frankfort	Clinton
Beasley, T. J.	Indianapolis	Marion
Bethea, Dennis	Hammond	Lake
Bethea, Robert O.	Farmersburg	Sullivan
Beaver, Ernest R.	Rensselaer	Jasper-Newton
Beaver, Howard W.	Indianapolis	Marion
Beaver, Norman	Berne	Adams
Bechtol, Lavon D.	Whiting	Lake
Bechtold, S. E.	South Bend	St. Joseph
Beck, Evart M.	Indianapolis	Marion
Beck, H. A.	Lebanon	Boone
Beck, Robert E.	Evansville	Vanderburgh
Becker, Philip H.	Crown Point	Lake
Beckes, Ellsworth	Vincennes	Knox
Beckes, Norman E. (H)	Vincennes	Knox
Beckman, H. F.	Indianapolis	Marion
Beconovich, Robert	Hammond	Lake
Bedwell, Marion H.	Sullivan	Sullivan
Beeler, Bruce H.	Evansville	Vanderburgh
Beeler, J. Moss	Lafayette	Tippecanoe
Beeler, John W.	Indianapolis	Marion
Beeler, Raymond C.	Indianapolis	Marion
Beetem, L. F.	Madison	Jefferson
Beggs, L. F.	Columbus	Bartholomew-Brown
Behn, Walter M.	Gary	Lake
Beierlein, Karl	Fort Wayne	Allen
Beilke, Clifford A.	East Chicago	Lake
Benchik, Frank A.	East Chicago	Lake
Bender, Cecil K.	Goshen	Elkhart
Bender, Robert L.	Elkhart	Elkhart
Bendler, Carl H.	Gary	Lake
Benedek, Tibor	East Chicago	Lake
Benedict, Charles D.	LaGrange	LaGrange
Benham, L. E.	Bedford	Lawrence
Bennett, Abner P.	Evansville	Vanderburgh
Bennett, J. B.	Warren	Huntington
Bennett, Jene R.	South Bend	St. Joseph
Benninghoff, D. R.	Fort Wayne	Allen
Benoit, Merrill T.	Anderson	Madison
Benz, Jesse	Marengo	Crawford
Benz, O. F.	Wanatah	LaPorte
Bergan, Joseph A.	South Bend	St. Joseph
Berger, Henry I.	Indianapolis	Marion
Berger, Morley	Beech Grove	Marion
Berghoff, Raymond	Fort Wayne	Allen
Berke, Robert	Mishawaka	St. Joseph

Name	City	County
Berkebile, J. B.	Peru	Miami
Berman, Edward J.	Indianapolis	Marion
Berman, Jacob K.	Indianapolis	Marion
Bernoske, D. G.	Michigan City	LaPorte
Berton, William M.	Indianapolis	Marion
Beverland, M. E.	Indianapolis	Marion
Biasini, Benedict A.	South Bend	St. Joseph
Bibler, Henry E.	Muncie	Delaware-Blackford
Bibler, L. D.	Indianapolis	Marion
Bickel, David A.	South Bend	St. Joseph
Bickel, J. E. (H)	Fort Wayne	Allen
Bigelow, O. P.	Roanoke	Huntington
Bigler, Frederick	Indianapolis	Marion
Billings, Elmer R.	Elkhart	Elkhart
Billman, Gustus S.	Shelbyville	Shelby
Bills, L. F.	Culver	Marshall
Bills, R. N.	Gary	Lake
Bird, Charles R. (H)	Indianapolis	Marion
Birdzell, John P.	Crown Point	Lake
Birge, Jackson P.	Elkhart	Elkhart
Birmingham, P. J.	South Bend	St. Joseph
Bishop, Charles A.	South Bend	St. Joseph
Bishop, Harry A.	Frankton	Madison
Bissonnette, Roger P.	Evansville	Vanderburgh
Bitler, C. C.	New Castle	Henry
Bixler, Louis C.	South Bend	St. Joseph
Bizer, Mier A.	Jeffersonville	Clark
Black, C. S.	Warren	Huntington
Black, Edgar K.	Wabash	Wabash
Black, Joe M.	Seymour	Jackson
Blackburn, Erwin	South Bend	St. Joseph
Blaize, J. L.	New Castle	Henry
Bland, H. E. (H)	Fairbanks	Sullivan
Blassaras, Chris	Anderson	Madison
Blatt, A. E.	Indianapolis	Marion
Blazey, A. G.	Washington	Daviess-Martin
Bledsoe, James G.	New Castle	Henry
Blemker, Russell M.	Greensburg	Decatur
Blessinger, Louis Henry	Corydon	Harrison
Blessinger, Paul J.	Jasper	Dubois
Blix, Fred M.	Ladoga	Montgomery
Bloemker, E. F.	Indianapolis	Marion
Bloom, Asa Ward	Marion	Grant
Bloom, George R.	Elkhart	Elkhart
Bloomer, J. R.	Rockville	Parke-Vermillion
Bloomer, R. S.	Rockville	Parke-Vermillion
Blosser, B. A.	Fremont	Steuben
Blosser, H. V. (H)	Fort Wayne	Allen
Blossom, Paul W.	Richmond	Wayne-Union
Blum, Leon L.	Terre Haute	Vigo
Boardman, Carl	Gary	Lake
Boaz, John J. (H)	Indianapolis	Marion
Bock, Don G.	Boone, Iowa	Marion
Bodnar, Leslie M.	South Bend	St. Joseph
Bogardus, C. R.	Austin	Scott
Boggs, E. F.	Indianapolis	Marion
Bohner, C. B.	Indianapolis	Marion
Bolin, John T.	Cedar Lake	Lake
Bolin, Robert S.	Elkhart	Elkhart
Boling, Grover C., Jr.	Indianapolis	Marion
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Bonaventura, A. P.	East Chicago	Lake
Bond, Charles S. (H)	Richmond	Wayne-Union
Bond, George S.	Indianapolis	Marion
Bond, Walter	Clay City	Clay
Bonifield, H. F.	Warren	Huntington
Booher, Norman R.	Indianapolis	Marion
Booher, Olga	Indianapolis	Marion
Booth, Boynton H.	Indianapolis	Marion
Bopp, Henry W.	Terre Haute	Vigo
Bopp, James	Terre Haute	Vigo
Borak, Walter J.	Gary	Lake
Borders, Theo. R.	Fort Wayne	Allen
Boren, Paul	Poseyville	Posey
Boren, Samuel W. (H)	Poseyville	Posey
Borland, R. M.	Bloomington	Owen-Monroe
Borough, L. D	South Bend	St. Joseph
Boswell, Robert W.	Evansville	Vanderburgh
Bothwell, C. G.	Martinsville	Morgan
Botkin, Clyde G.	Muncie	Delaware-Blackford
Botkin, Thomas	Muncie	Delaware-Blackford
Bottorff, David C.	Charlestown	Clark
Boughman, Joseph D.	Kokomo	Howard
Bounnell, Harry M. (H)	Waynetown	Montgomery
Bowdoin, G. E.	Elkhart	Elkhart
Bowen, Otis R.	Bremen	Marshall
Bowers, Copeland C.	Kokomo	Howard
Bowers, Don L.	Indianapolis	Marion
Bowers, G. T.	Fort Wayne	Allen
Bowers, Garvey B.	Kokomo	Howard
Bowers, John A.	Kokomo	Howard
Bowers, J. W.	Fort Wayne	Allen
Bowles, J. H.	Muncie	Delaware-Blackford
Bowman, Charles M.	Albion	Noble
Bowman, George W.	Indianapolis	Marion
Boyd, C. L.	Vincennes	Knox
Boyd, Charles S.	East Chicago	Lake
Boyd, Clarence E.	West Baden	Orange
Boyd, Foster J., Jr.	Wilmington, O.	Marion
Boyd, Stella N.	Evansville	Vanderburgh
Boyer, E. B.	Indianapolis	Marion
Boyer, Floyd A.	Indianapolis	Marion
Boyer, Grace B.	Marion	Grant
Boys, F. F.	East Chicago	Lake
Bradfield, John C.	Logansport	Cass
Bradley, Stephen C.	Terre Haute	Vigo
Brady, Samuel	Gary	Lake
Brady, Thomas A.	Indianapolis	Marion
Brandman, Harry	Gary	Lake
Brauchla, C. H.	Anderson	Madison
Brauer, Abraham A.	East Chicago	Lake
Braun, Benjamin D.	Chicago, Ill.	Lake
Braunlin, Robert F.	Marion	Grant
Braunlin, W. H.	Marion	Grant
Brayton, John R.	Indianapolis	Marion
Brayton, Lee	Indianapolis	Marion
Brazelton, O. T.	Princeton	Gibson
Brechtol, Harvey J.	Green Cove Springs, Fla.	St. Joseph
Brenner, I. E.	Winchester	Randolph
Bretz, John M.	Huntingburg	Dubois
Brickley, H. D.	Bluffton	Wells
Brickley, Richard A.	Bluffton	Wells
Bridges, William L.	Indianapolis	Marion
Bridwell, Edgar	Bedford	Lawrence
Briggs, Carl F.	Sullivan	Sullivan
Briggs, J. H.	Churubusco	Whitley
Brink, Calvin C.	Gary	Lake
Brincko, John	Indianapolis	Marion
Briscoe, C. E.	New Albany	Floyd
Britton, W. D.	Montezuma	Parke-Vermillion
Brock, Earl E.	Anderson	Madison
Brockman, Wilfred	Corydon	Harrison
Brockmole, Arnold W.	Evansville	Vanderburgh
Brodie, Donald W.	Indianapolis	Marion
Bronson, Paul J.	Terre Haute	Vigo
Brookie, Roger Wm.	Flora	Carroll
Brooks, H. L.	Michigan City	LaPorte
Broomes, Edward L. C.	East Chicago	Lake
Broshears, Kenneth	Linton	Greene
Brosius, Robert H. W.	Ft. Wayne	Allen
Brother, Geo. M.	Oklahoma City, Okla.	Marion
Brown, A. E.	Indianapolis	Marion

Name	City	County
Brown, D. B.	Gary	Lake
Brown, David E.	Indianapolis	Marion
Brown, Dewitt W.	Indianapolis	Marion
Brown, Edward A. (H)	Indianapolis	Marion
Brown, Frances T.	Indianapolis	Marion
Brown, Frederic W.	Ft. Wayne	Allen
Brown, George E.	Greenwood	Johnson
Brown, James A., Sr.	Evansville	Vanderburgh
Brown, James C.	Valparaiso	Porter
Brown, James M.	Anderson	Madison
Brown, J. S.	Carlisle	Sullivan
Brown, K. H.	New Albany	Floyd
Brown, Leland G.	Muncie	Delaware-Blackford
Brown, Leo R.	Gary	Lake
Brown, Marcel S.	Spencer	Owen-Monroe
Brown, R. E.	Cayuga	Parke-Vermillion
Brown, R. L.	Evansville	Vanderburgh
Brown, Robert R.	Terre Haute	Vigo
Brown, Robert M.	Marion	Grant
Brown, Stanley L.	Hammond	Lake
Brown, Stewart D.	Albany	Delaware-Blackford
Brown, Thomas	Delphi	Carroll
Brown, Thomas M.	Muncie	Delaware-Blackford
Brown, Wendell E.	Indianapolis	Marion
Browne, William A.	Evansville	Vanderburgh
Browning, J. S.	Indianapolis	Marion
Browning, W. M.	Indianapolis	Marion
Brubaker, Harold S.	Huntington	Huntington
Brubaker, O. G. (H)	N. Manchester	Wabash
Bruegge, T. J.	Kokomo	Howard
Bruetsch, Walter L.	Indianapolis	Marion
Bruggeman, H. O.	Ft. Wayne	Allen
Bruner, Ralph	Jeffersonville	Clark
Bryan, F. A.	Ft. Wayne	Allen
Bryan, Robert E.	Kendallville	Noble
Bryan, Robert J.	South Bend	St. Joseph
Bryan, S. L.	Evansville	Vanderburgh
Buchanan, W. D.	South Bend	St. Joseph
Buche, F. P.	Richmond	Wayne-Union
Buchholz, Ransom R.	Evansville	Vanderburgh
Buck, Charles E.	Indianapolis	Marion
Buckingham, Richard	Bloomington	Owen-Monroe
Buckles, David L.	Anderson	Madison
Buckley, E. P.	Jeffersonville	Clark
Buckner, Doster	Ft. Wayne	Allen
Buckner, George D.	Fort Wayne	Allen
Buckner, Joy F.	Bluffton	Wells
Buechner, F. W.	South Bend	St. Joseph
Buehner, Donald F.	Evansville	Vanderburgh
Buhrmester, H. C.	Lafayette	Tippecanoe
Buikstra, C. R.	Evansville	Vanderburgh
Bullard, Mattie J.	Gary	Lake
Bulson, Eugene L.	Ft. Wayne	Allen
Bunde, Carl	Indianapolis	Marion
Bundy, C. Merle	Pittsburgh, Pa.	Marion
Bunker, L. Z.	N. Manchester	Wabash
Burcham, J. B.	Gary	Lake
Burdette, Harold F.	Indianapolis	Marion
Burge, A. D. (H)	Marion	Grant
Burghard, D. Rolla	Indianapolis	Marion
Burk, James M.	Decatur	Adams
Burket, Cecil R.	South Bend	St. Joseph
Burkhardt, B. A.	Tipton	Tipton
Burkle, J. C.	Lafayette	Tippecanoe
Burks, Jess E.	Crawfordsville	Montgomery
Burman, Richard G.	Jeffersonville	Clark
Burnett, Arthur B.	New Castle	Henry
Burney, Leroy E.	Indianapolis	Marion
Burnikel, Ray H.	Evansville	Vanderburgh
Burns, Kendall R.	Lafayette	Tippecanoe
Burns, Paul E.	Montpelier	Delaware-Blackford
Burress, B. O.	Washington	Daviess-Martin
Burris, F. L.	Michigan City	LaPorte
Burroughs, C. A.	Frankfort	Clinton
Burrous, E. Lee	Peru	Miami
Bush, Hargis R.	Cannelton	Perry
Bussard, C. F.	South Bend	St. Joseph
Bussard, Frank	South Bend	St. Joseph
Butler, John O.	Indianapolis	Marion
Butler, Robert M.	Indianapolis	Marion
Butman, W. C.	Hebron	Porter
Butterfield, Robt. M.	Muncie	Delaware-Blackford
Buttz, Rose J.	Indianapolis	Marion
Buxton, Eva (H)	W. Memphis, Ark.	Spencer
Byrn, H. W.	New Albany	Floyd
Byrne, Robert J.	Bicknell	Knox
C		
Cacia, John J.	Evansville	Vanderburgh
Cahal, Ernest	Indianapolis	Marion
Cahn, Hugo M.	Indianapolis	Marion
Cajacob, Melville E.	Terre Haute	Vigo
Caldwell, Marilyn	Indianapolis	Marion
Caldwell, William C.	Evansville	Vanderburgh
Call, Earle B.	Knightstown	Henry
Call, H. F.	Indianapolis	Marion
Callaghan, W. C.	Greensburg	Decatur
Callahan, R. H.	East Chicago	Lake
Calli, Louis	North Vernon	Jennings
Calvert, R. R.	Lafayette	Tippecanoe
Calvin, Jessie C. (H)	Ft. Wayne	Allen
Cameron, D. F.	Ft. Wayne	Allen
Campagna, E. A.	East Chicago	Lake
Campbell, Guy G.	Munster	Lake
Campbell, J. A.	Indianapolis	Marion
Campbell, P. A.	Richmond	Wayne-Union
Campbell, Sam W.	Carmel	Hamilton
Canaday, C. E. (H)	New Castle	Henry
Canaday, J. W. (H)	Indianapolis	Marion
Cannon, Daniel H.	New Albany	Floyd
Caplin, Irvin	Indianapolis	Marion
Caplin, S. S.	Indianapolis	Marion
Carbone, J. A.	Gary	Lake
Carey, W. W. (H)	Ft. Wayne	Allen
Carlberg, D. L.	Jeffersonville	Clark
Carleton, E. H.	East Chicago	Lake
Carlo, Ernest R.	Ft. Wayne	Allen
Carlo, J. F.	Hammond	Lake
Carlson, Charles E.	Indianapolis	Marion
Carlson, E. A. (H)	Peru	Miami
Carlson, Norman C.	Michigan City	LaPorte
Carlyle, Ivan E.	Michigantown	Clinton
Carmichael, C. S.	Seelyville	Vigo
Carmody, R. F.	Gary	Lake
Carneal, Thomas E.	Winamac	Pulaski
Carney, J. T.	Jeffersonville	Clark
Carney, John C.	Monticello	White
Carpenter, G. C.	Terre Haute	Vigo
Carpenter, J. L.	Alexandria	Madison
Carpenter, Thomas D.	Columbus	Bartholomew-Brown
Carpentier, Harry F.	Princeton	Gibson
Carrel, Francis E.	Frankfort	Clinton
Carroll, John C.	Decatur	Adams
Carroll, Bertha Rose	W. Lafayette	Tippecanoe
Carroll, Mary E.	Crown Point	Lake
Carson, Wayne	Indianapolis	Marion
Carter, F. R. Nicholas	South Bend	St. Joseph
Carter, Fred S.	LaPorte	LaPorte
Carter, James C.	Indianapolis	Marion
Carter, J. V.	Tipton	Tipton
Carter, Oren E.	Indianapolis	Marion
Cartwright, E. L.	Ft. Wayne	Allen
Cartwright, Jack D.	LaPorte	LaPorte

Name	City	County
Casebeer, P. B.	Clinton	Parke-Vermillion
Caseley, Donald	Indianapolis	Marion
Casey, Stanley M.	Huntington	Huntington
Casper, Joseph F.	Jasper	Dubois
Cassady, J. V.	South Bend	St. Joseph
Catlett, M. B.	Ft. Wayne	Allen
Caton, J. R.	South Bend	St. Joseph
Cavins, A. W.	Terre Haute	Vigo
Cavitt, Robert F.	Connersville	Fayette-Franklin
Cayley, Frank J.	Indianapolis	Marion
Caylor, Harold D.	Bluffton	Wells
Caylor, Truman E.	Bluffton	Wells
Challman, W. B.	Mt. Vernon	Posey
Chambers, A. R.	Ft. Wayne	Allen
Chambers, L. B.	Union City	Randolph
Chambers, William	South Bend	St. Joseph
Chandler, L. H.	Millersburg	Elkhart
Chattin, Herbert O.	Vincennes	Knox
Chattin, Robert E.	Loogootee	Daviess-Martin
Chattin, William R.	Indianapolis	Marion
Chattin, V. J.	Washington	Daviess-Martin
Chen, K. K.	Indianapolis	Marion
Chevigny, J. J.	Gary	Lake
Chidlaw, B. W.	Hammond	Lake
Childs, A. G. W. (H)	Madison	Jefferson
Childs, Wallace E.	Madison	Jefferson
Chittick, A. G.	Frankfort	Clinton
Christophel, Verna	Mishawaka	St. Joseph
Chroniak, Walter	Indianapolis	Marion
Clancy, J. F.	Hammond	Lake
Clark, C. P.	Indianapolis	Marion
Clark, Cyrus J.	Indianapolis	Marion
Clark, Fred O.	Syracuse	Kosciusko
Clark, Ivan A.	Paoli	Orange
Clark, Joseph H.	Kendallville	Noble
Clark, Lawson J.	Indianapolis	Marion
Clark, M. E.	Cambridge City	Wayne-Union
Clark, Stanley A.	South Bend	St. Joseph
Clark, William B., Jr.	Jeffersonville	Clark
Clark, Wm. H.	South Bend	St. Joseph
Clark, W. R.	Ft. Wayne	Allen
Clarke, Elton R.	Kokomo	Howard
Clauser, E. H.	Muncie	Delaware-Blackford
Clements, A. F.	Evansville	Vanderburgh
Clevenger, J. H.	Muncie	Delaware-Blackford
Clevinger, Wm. G.	Indianapolis	Marion
Cline, Kenneth L.	Wyatt	St. Joseph
Close, W. D.	Indianapolis	Marion
Clouse, Paul A.	Evansville	Vanderburgh
Clunie, Wm. A.	Huntington	Huntington
Coble, F. H.	Richmond	Wayne-Union
Coble, R. R.	Indianapolis	Marion
Cockrum, Wm. M.	Evansville	Vanderburgh
Cody, B. L.	Evansville	Vanderburgh
Coffel, Melvin H.	Vincennes	Knox
Coffman, Delmar Lee	Clinton, Okla.	Vanderburgh
Cohn, Alvin C.	Indianapolis	Marion
Cohen, Irving	Plainfield	Hendricks
Cole, A. V.	East Chicago	Lake
Cole, Ira	Lafayette	Tippecanoe
Cole, Russel E.	Muncie	Delaware-Blackford
Coleman, Floyd B.	Waterloo	Dekalb
Coleman, H. G.	Odon	Daviess-Martin
Coleman, Joseph E.	Evansville	Vanderburgh
Colglazier, G. G.	Leipsic	Orange
Colip, George	South Bend	St. Joseph
Collins, Albert W. (H)	Anderson	Madison
Collins, Hubert L.	Indianapolis	Marion
Collins, J. N.	Indianapolis	Marion
Combs, Charles N.	Terre Haute	Vigo
Combs, Herman	Evansville	Vanderburgh
Combs, John H.	Evansville	Vanderburgh
Combs, Loyal	Lowell	Lake
Combs, Nelson B.	Mulberry	Clinton
Combs, Pearl B.	Evansville	Vanderburgh
Combs, Stuart R.	Terre Haute	Vigo
Comer, Charles W.	Mooresville	Morgan
Comer, J. E.	Mooresville	Morgan
Comer, Kenneth E.	Mooresville	Morgan
Compton, C. B.	Frankfort	Clinton
Compton, George	Tipton	Tipton
Compton, Walter A.	Elkhart	Elkhart
Condit, David H.	South Bend	St. Joseph
Congleton, G. C.	Terre Haute	Vigo
Conklin, James O.	Terre Haute	Vigo
Conklin, R. L.	Elkhart	Elkhart
Conley, John E.	Ft. Wayne	Allen
Conley, Joseph L.	Indianapolis	Marion
Conley, T. M.	Kokomo	Howard
Connell, P. S.	Plymouth	Marshall
Connell, Vactor O.	Bourbon	Marshall
Conner, T. E. (H)	Freetown	Jackson
Connerly, M. L.	San Diego, Calif.	Marion
Connoy, Andrew F.	Westfield	Hamilton
Connoy, Leo	Westfield	Hamilton
Conrad, E. M. (H)	Anderson	Madison
Conrad, Henry W.	Milan	Ripley
Conway, Chester C.	Indianapolis	Marion
Conway, Glenn	Indianapolis	Marion
Cook, C. J. (H)	Indianapolis	Marion
Cook, Charles E.	North Manchester	Wabash
Cook, G. M.	Hammond	Lake
Cook, Gordon C.	South Bend	St. Joseph
Cook, Norman R.	Richmond	Wayne-Union
Cook, Robert G.	Bluffton	Wells
Cooksey, T. L. (H)	Crawfordsville	Montgomery
Coomes, M. J. (H)	Shelbyville	Shelby
Cooney, Charles J.	Ft. Wayne	Allen
Coons, John D.	Lebanon	Boone
Coons, Ritchie	Lebanon	Boone
Cooper, H. L.	South Bend	St. Joseph
Cooper, Leo Kenneth	Gary	Lake
Cooper, Thomas L.	Logansport	Cass
Cope, Stanton E.	Huntington	Huntington
Copeland, G. W. (H)	Vevay	Switzerland
Copeland, S. J.	Indianapolis	Marion
Corcoran, Patrick J. V.	Evansville	Vanderburgh
Cormican, Herbert L.	Elkhart	Elkhart
Cornacchione, M.	Indianapolis	Marion
Cornell, Beaumont S.	Ft. Wayne	Allen
Cornell, Robert A.	Crawfordsville	Montgomery
Corpe, Kenneth F.	Rushville	Rush
Cortese, James V.	Indianapolis	Marion
Cortese, Thomas A.	Indianapolis	Marion
Cotter, E. R.	East Chicago	Lake
Cotterman, Vernon L.	Gary	Lake
Cotton, S. M.	Goldsmith	Tipton
Coulson, S. B.	Waldron	Shelby
Coultas, P. J.	Tell City	Perry
Courtney, John W.	Indianapolis	Marion
Covalt, Wendell E.	Muncie	Delaware-Blackford
Covell, H. M.	Auburn	Dekalb
Cox, C. E.	Indianapolis	Marion
Cox, Harold	Indianapolis	Marion
Cox, Leon T.	Richmond	Wayne-Union
Cox, W. T.	Lafayette	Tippecanoe
Coyner, A. B.	Lafayette	Tippecanoe
Craft, K. L.	Indianapolis	Marion
Craft, William F.	Linton	Greene
Craig, Alexander F.	New Castle	Henry
Craig, R. A.	Kokomo	Howard
Craig, Robert A.	Syracuse	Kosciusko
Craig, Richard M.	Ft. Wayne	Allen

Name	City	County
Craigmile, Thomas	Oakville	Delaware-Blackford
Crain, James Wm.	Williamsport	Fountain-Warren
Crampton, C. C. (H)	Delphi	Carroll
Crandall, Latham A.	Elkhart	Elkhart
Craven, Howard	Indianapolis	Marion
Crawford, James H.	Evansville	Vanderburgh
Crawford, John A.	Indianapolis	Marion
Crawford, T. R.	Kokomo	Howard
Crawford, William G.	Terre Haute	Vigo
Creel, Donald	Angola	Steuben
Crevello, Albert J.	Evansville	Vanderburgh
Crimm, Paul D.	Evansville	Vanderburgh
Cring, George	Portland	Jay
Cripe, E. P.	Bremen	Marshall
Crockett, F. S.	Lafayette	Tippecanoe
Crossland, Stewart H.	Gary	Lake
Crowder, James H., Jr.	Sullivan	Sullivan
Crum, Marion M.	Angola	Steuben
Culbertson, C. S.	South Bend	St. Joseph
Culbertson, Clyde G.	Indianapolis	Marion
Cullen, P. K.	Indianapolis	Marion
Cullipher, J .E. (H)	Elwood	Madison
Cullison, Charles W.	Vincennes	Knox
Cullnane, C. W.	Evansville	Vanderburgh
Culloden, William G.	Indianapolis	Marion
Culmer, W. N. (H)	Bloomington	Owen-Monroe
Culp, John E.	Ft. Wayne	Allen
Cummings, D. J.	Brownstown	Jackson
Cunningham, J. M.	Indianapolis	Marion
Cunningham, Robert D.	South Bend	St. Joseph
Cure, Charles W.	Indianapolis	Marion
Cure, Elmer T.	Muncie	Delaware-Blackford
Currie, Robert W.	Marion	Grant
Curry, Claude A.	Terre Haute	Vigo
Curtner, M. L.	Vincennes	Knox
Cusack, Robert	Indianapolis	Marion
Custer, E. W.	South Bend	St. Joseph
Cuthbert, F. S.	Kokomo	Howard
Cuthbert, M. P.	Indianapolis	Marion

D

Dahling, C. W.	New Haven	Allen
Dailey, J. E.	Indianapolis	Marion
Dainko, A. J.	East Chicago	Lake
Dale, J. W.	Chesterton	Porter
Dale, Maxwell H.	Connersville	Fayette-Franklin
Daley, Edward H.	Oldenburg	Fayette-Franklin
Dalton, John E.	Indianapolis	Marion
Dalton, Naomi	Bloomington	Owen-Monroe
Dalton, William W.	Indianapolis	Marion
Dalton, Wilson L.	Shelbyville	Shelby
Dancer, C. R. (H)	Fort Wayne	Allen
Dando, George H. (H)	Hartford City	Delaware-Blackford
Daniel, J. C.	Indianapolis	Marion
Danieleski, L. J.	Gary	Lake
Daniels, E. O.	Marion	Grant
Daniels, G. R.	Marion	Grant
Dannacher, William D.	Wabash	Wabash
Dare, Lee A.	Jeffersonville	Clark
Darling, Dorothy	Gary	Lake
Darroch, S. C.	Cayuga	Parke-Vermillion
Dassell, Paul Milton	Dyer	Lake
Datzman, Richard C.	Fort Wayne	Allen
Daubenheyer, M. F. (H)	Richmond	Wayne-Union
Daugherty, F. N.	Crawfordsville	Montgomery
Daves, W. L.	Evansville	Vanderburgh
Davidoff, Manuel A.	Ossian	Wells
Davidson, N. Cort	Indianapolis	Marion
Davis, Alice H.	Hammond	Lake
Davis, Carl M.	Valparaiso	Porter
Davis, E. C.	Muncie	Delaware-Blackford
Davis, J. A.	Flat Rock	Shelby
Davis, John A.	Indianapolis	Marion
Davis, John C.	Logansport	Cass
Davis, Joseph B.	Marion	Grant
Davis, M. S.	Marion	Grant
Davis, Marvin R.	Columbus	Bartholomew-Brown
Davis, Neal	Gary	Lake
Davis, Parvin M.	New Albany	Floyd
Davis, Richard	Marion	Grant
Davis, Sam J.	Indianapolis	Marion
Davis, William	New Market	Montgomery
Day, George H.	New Albany	Floyd
Day, Theodore P.	Willoughey, O.	Vigo
Day, W. D. C.	Seymour	Jackson
Deal, Eleanor H.	Speedway City	Marion
Dean, Donald I.	Rushville	Rush
Dearmin, R. M.	Indianapolis	Marion
DeArmond, Murray	Indianapolis	Marion
Decker, H. B.	Terre Haute	Vigo
DeDario, L. M.	Elkhart	Elkhart
Deever, J. W.	Indianapolis	Marion
DeFries, John J.	New Paris	Elkhart
DeGrazia, E. J.	Valparaiso	Porter
DeLong, C. A. (H)	Gary	Lake
DeMotte, C. Bowen	Indianapolis	Marion
DeMotte, Russell A.	Bloomington	Owen-Monroe
DeNaut, J. F.	Knox	Starke
Denham, Robert H.	South Bend	St. Joseph
Denman, R. D. (H.)	Helmer	Steuben
Denny, Edgar C.	Milton	Wayne-Union
Denny, E. Rankin	Washington	Daviess-Martin
Denny, Fred C.	Madison	Jefferson
Denny, Forrest L.	Indianapolis	Marion
Denny, Frank T.	Ladoga	Montgomery
Denny, J. W.	Indianapolis	Marion
Denny, Melvin H.	Rushville	Rush
Denton, Larkin D.	Greentown	Howard
Denzer, E. K.	Evansville	Vanderburgh
Denzer, Wm. Oliver	Evansville	Vanderburgh
Deppe, Charles F.	Franklin	Johnson
Derhammer, G. L.	Brookston	White
DeRyke, Gilbert R.	Winchester	Randolph
DesJean, Paul A.	Indianapolis	Marion
Dester, Herbert E.	Jagdeeshpur, India	Marion
DeTar, G. B. (H)	Winslow	Pike
Detrick, H. W.	Hammond	Lake
Dettloff, Frederick	Greencastle	Putnam
Deutsch, Wm.	Muncie	Delaware-Blackford
DeVoe, Kenneth	Woodburn	Allen
DeWees, Dwight L.	Indianapolis	Marion
Dewey, Fred N. (H)	Elkhart	Elkhart
Dewey, Geo. W. (H)	Lafayette	Tippecanoe
DeWitt, C. H. (H)	Valparaiso	Porter
Diamond, Leo	Marion	Grant
Dian, A. J.	Gary	Lake
Dian, Julia G. Kuzmitz	Gary	Lake
Dick, Fred, Jr.	Marion	Grant
Dickson, D. D.	Greensburg	Decatur
Dieckman, Herbert S.	Evansville	Vanderburgh
Diefendorf, Charles F. (H)	Evansville	Vanderburgh
Dielman, F. C.	Fulton	Fulton
Dierolf, Edward J.	Gary	Lake
Dietl, E. L.	South Bend	St. Joseph
Dillman, Carl E.	Corydon	Harrison
Dilts, Robert	Indianapolis	Marion

Name	City	County
Dingle, Paul	Richmond	Wayne-Union
Dininger, W. S.	Winchester	Randolph
Dintaman, Paul G.	Indianapolis	Marion
Dittmer, J. E.	Valparaiso	Porter
Dittmer, S. E.	Kouts	Porter
Dittmer, Thomas L.	Indianapolis	Marion
Ditton, I. W. (H)	Ft. Wayne	Allen
Dixon, Rex	Anderson	Madison
Dobbs, O. R.	Greencastle	Putnam
Dodd, Robert D.	South Bend	St. Joseph
Dodd, Roberts K.	Evansville	Vanderburgh
Dodds, James U.	Hartford City	Delaware-Blackford
Dodds, Wemple	Crawfordsville	Montgomery
Doenges, James L.	Anderson	Madison
Dolezal, Bernard J.	South Bend	St. Joseph
Dollens, Claude	Oolitic	Lawrence
Dome, H. S. (H)	Tell City	Perry
Donahue, C. M.	Carmel	Hamilton
Donahue, G. R.	Lafayette	Tippecanoe
Donato, Albert M.	Indianapolis	Marion
Donchess, J. C.	Gary	Lake
Donham, William L.	Bicknell	Knox
Donnelly, Everett F.	South Bend	St. Joseph
Donner, Paul G.	Indianapolis	Marion
Donovan, Joseph W.	Morocco	Jasper-Newton
Donovan, S. J.	Michigan City	La Porte
Dorman, W. L.	Indianapolis	Marion
Dorrance, T. O.	Bluffton	Wells
Dorsey, Philip W.	Terre Haute	Vigo
Doty, J. R.	Gary	Lake
Douglas, G. R. (H)	Valparaiso	Porter
Douglas, William T.	Montpelier	Delaware-Blackford
Dowd, Joseph A.	Indianapolis	Marion
Dowell, E. H.	Rockville	Parke-Vermillion
Downard, Leland F.	Gaston	Delaware-Blackford
Dragoo, Farrol	Middletown	Henry
Drake, John C.	Anderson	Madison
Drake, M. C.	Elwood	Madison
Drake, William L.	Indianapolis	Marion
Draper, M. H.	Tampa, Fla.	Allen
Dreyer, Ralph W.	Knightstown	Henry
Dryden, Gale E.	Indianapolis	Marion
Dublin, Madeline P.	Francesville	Pulaski
Dubois, F. T. (H)	Liberty	Wayne-Union
Dubois, R. B.	Lafayette	Tippecanoe
Dudding, J. E.	Hope	Bartholomew-Brown
Duemling, Arnold H.	Ft. Wayne	Allen
Dugan, Thomas J.	Indianapolis	Marion
Dugan, Wm. M.	Indianapolis	Marion
Duggan, J. A.	South Bend	St. Joseph
Duke, B. E.	Decatur	Adams
Dukes, Betty	Dugger	Sullivan
Dukes, David A.	Tell City	Perry
Dukes, F. M.	Dugger	Sullivan
Dukes, Joe E.	Dugger	Sullivan
Dulin, Basil B.	Portland	Jay
Dunbar, Colin V.	Indianapolis	Marion
Duncan, J. S.	Gary	Lake
Duncan, Wm. F. (H)	Aurora	Dearborn-Ohio
Dunham, Wilbur F.	Kempton	Tipton
Dunlap, D. Logan	South Bend	St. Joseph
Dunn, F. W.	Muncie	Delaware-Blackford
Dunning, L. M.	Indianapolis	Marion
Dunstone, H. C.	Ft. Wayne	Allen
Dupes, L. E.	Hobart	Lake
Durkee, M. S.	Evansville	Vanderburgh
Dusard, Joseph C.	Bedford	Lawrence
Dutchess, C. T.	Galveston	Cass
Dyar, E. W.	Indianapolis	Marion
Dycus, W. A.	Evansville	Vanderburgh
Dyer, G. W.	Terre Haute	Vigo
Dyer, Wallace K.	Evansville	Vanderburgh
Dyke, Richard W.	Indianapolis	Marion
Dykhuizen, T. A.	Frankfort	Clinton

E

Eades, Ralph C.	Valparaiso	Porter
Earl, Max M.	Kokomo	Howard
Earp, Evanson B.	Indianapolis	Marion
Eastman, J. R., Jr.	Indianapolis	Marion
Eaton, E. R.	Indianapolis	Marion
Eaton, L. D.	Franklin	Johnson
Eaton, M. J.	Lafayette	Tippecanoe
Ebbinghouse, Tom	Richmond	Wayne-Union
Ebert, J. Wayne	Indianapolis	Marion
Eberwein, J. H.	Indianapolis	Marion
Eby, Ida L.	Goshen	Elkhart
Eckert, Russell A.	Indianapolis	Marion
Edlavitch, B. M.	Ft. Wayne	Allen
Edmonds, Kendrick	Bedford	Lawrence
Edmondson, R. E.	Terre Haute	Vigo
Edwards, Bernard	South Bend	St. Joseph
Edwards, Edward T., Jr.	Vincennes	Knox
Edwards, W. F.	New Albany	Floyd
Egan, Sherman	South Bend	St. Joseph
Egbert, Clarence	Muncie	Delaware-Blackford
Egbert, Herbert	Indianapolis	Marion
Egbert, Roy	Indianapolis	Marion
Eggers, E. L.	Hammond	Lake
Eggers, H. W.	Hammond	Lake
Egnatz, Nicholas	Hammond	Lake
Ehrich, W. S.	Evansville	Vanderburgh
Ehrman, C. D.	Rockport	Spencer
Eicher, Palmer	Indianapolis	Marion
Eickenberry, H. W.	Indianapolis	Marion
Eisaman, Jack L.	Bluffton	Wells
Eisenberg, D. A.	Martinsville	Morgan
Eisenlohr, Eugen	Terre Haute	Vigo
Eisterhold, John A.	Evansville	Vanderburgh
Eldridge, Gail E.	Indianapolis	Marion
Elledge, Ray	Hammond	Lake
Ellerbrook, George E.	Vevay	Switzerland
Ellett, John, Jr.	Coatesville	Hendricks
Elliott, John C.	Guilford	Dearborn-Ohio
Elliott, L. A.	Elkhart	Elkhart
Elliott, R. A.	Gary	Lake
Elliott, R. H.	Indianapolis	Marion
Elliott, Thomas A.	New Orleans, La.	Elkhart
Ellis, Bert	Indianapolis	Marion
Ellis, Davis W., Jr.	Rushville	Rush
Ellis, George M.	Connersville	Fayette-Franklin
Ellis, Lyman H.	Lizton	Hendricks
Ellis, Seth	Anderson	Madison
Ellison, Alfred	South Bend	St. Joseph
Elshout, Clem H.	LaPorte	LaPorte
Elsner, L. W.	Seymour	Jackson
Elsten, A. W.	Anderson	Madison
Elston, L. W.	Ft. Wayne	Allen
Elston, Ralph W.	Ft. Wayne	Allen
Emenhiser, Donald C.	New Haven	Allen
Emenhiser, John L.	New Haven	Allen
Emery, Charles B.	Bedford	Lawrence
Emhardt, J. W. A.	Indianapolis	Marion
Emhardt, John T.	Indianapolis	Marion
Emme, R. W.	Harlan	Allen
Endicott, Wayne	Greenfield	Hancock
Engel, E. L.	Evansville	Vanderburgh
Engeler, J. E.	Lafayette	Tippecanoe
Engle, J. M.	Portland	Jay
Engle, Russell B.	Winchester	Randolph

Name	City	County
Engleman, H. K.	Georgetown	Floyd
English, H. E.	Rensselaer	Jasper-Newton
English, H. M.	Gary	Lake
English, J. P.	South Bend	St. Joseph
Ensminger, L. A.	Indianapolis	Marion
Entner, Charles L.	Connersville	Fayette-Franklin
Enzor, O. K.	Indianapolis	Marion
Episcopo, A. R.	Salem	Washington
Erdel, Milton W.	Frankfort	Clinton
Erehart, A. D.	Anderson	Madison
Erehart, M. G.	Huntington	Huntington
Ericksen, Lester G.	South Bend	St. Joseph
Erickson, Gustaf W.	South Bend	St. Joseph
Ericson, H. L.	Windfall	Tipton
Ernst, Clifford	Indianapolis	Marion
Ernst, H. C.	East Chicago	Lake
Eshleman, L. H. (H)	Marion	Grant
Estes, Ambrose C.	Bloomington	Owen-Monroe
Estlick, R. E.	Ft. Wayne	Allen
Evans, Frederick H.	Indianapolis	Marion
Evans, Frederick J.	Clinton	Parke-Vermillion
Evans, Paul V.	Indianapolis	Marion
Evans, R. M.	Russiaville	Howard
Everly, Ralph	Indianapolis	Marion
Eviston, J. V.	Huntington	Huntington
Ewbank, J. Nelson	Richmond	Wayne-Union
Ewing, Nathaniel D.	Vincennes	Knox

F

Fagaly, W. J.	Lawrenceburg	Dearborn-Ohio
Failey, Robert	Indianapolis	Marion
Fair, John R.	Augusta, Ga.	Noble
Faith, I. L.	Newburgh	Warrick
Faltin, Ladislaus	South Bend	St. Joseph
Farabee, Charles R.	North Judson	Starke
Fargher, F. M.	Michigan City	La Porte
Fargher, R. A.	La Porte	La Porte
Farnsworth, S. A.	La Porte	La Porte
Farr, James	Martinsville	Morgan
Farrell, J. T.	Indianapolis	Marion
Farris, John J.	Washington	Daviess-Martin
Farver, M. A. (H)	Middlebury	Elkhart
Faul, Henry J.	Evansville	Vanderburgh
Faulkner, W. H.	Nashville, Tenn.	Wayne-Union
Fausset, C. Basil	Indianapolis	Marion
Feerer, Donald J.	Michigan City	La Porte
Fein, Harry S.	Michigan City	LaPorte
Feldman, Max	South Bend	St. Joseph
Fender, A. H.	Worthington	Greene
Ferguson, A. N.	Little Rock, Ark.	Allen
Ferguson, John T.	Hamlet	Starke
Ferguson, Wm. B.	W. Lafayette	Marion
Ferrara, Donald W.	Peru	Miami
Ferrara, Joseph F.	Franklin	Johnson
Ferrara, S. J.	Peru	Miami
Ferrell, Jesse E.	Fortville	Hancock
Ferrell, Mars B.	Fortville	Hancock
Ferry, John L.	Whiting	Lake
Ferry, P. W.	Kokomo	Howard
Fessler, G. S.	Rising Sun	Dearborn-Ohio
Fichman, A. M.	Fort Wayne	Allen
Fickas, Dallas	Evansville	Vanderburgh
Filipek, W. J.	South Bend	St. Joseph
Fipp, August L.	Rome City	Noble
Firestein, Ben	South Bend	St. Joseph
Firestein, Ray	Chicago, Ill.	St. Joseph
Fisch, Charles	Indianapolis	Marion
Fischer, Burnell	Hammond	Lake
Fischer, C. N.	La Porte	La Porte
Fischer, W. E.	Anderson	Madison
Fish, C. M.	South Bend	St. Joseph
Fish, Edson C.	South Bend	St. Joseph
Fisher, Gerald	Cleveland, O.	Marion
Fisher, Henry	Marion	Grant
Fisher, John E.	Attica	Fountain-Warren
Fisher, John E.	New Castle	Henry
Fisher, Lawrence F.	South Bend	St. Joseph
Fisher, Walter S.	Columbus	Bartholomew-Brown
Fisher, William C.	Evansville	Vanderburgh
Fisk, Frank B.	Indianapolis	Marion
Fitch, Ray T.	Muncie	Delaware-Blackford
Fitzgerald, Brice E.	Logansport	Cass
Fitz Gerald, Maurice D.	Evansville	Vanderburgh
Fitzgerald, William J.	Indianapolis	Marion
Fitzpatrick, James S.	Portland	Jay
Fitzsimmons, E. L.	Evansville	Vanderburgh
Flack, Russell A.	Lafayette	Tippecanoe
Flaherty, Walter T.	Michigan City	La Porte
Flanagan, E. P.	Walton	Cass
Flanigan, M. B.	Indianapolis	Marion
Flannigan, H. F.	LaGrange	LaGrange
Fleetwood, R. A.	Nappanee	Elkhart
Fleischer, J. C.	East Chicago	Lake
Fleming, C. F.	Elkhart	Elkhart
Fleming, Justus M.	Elkhart	Elkhart
Fletcher, Charles F.	Sunman	Ripley
Flick, John J.	Indianapolis	Marion
Flinn, John H.	Evansville	Vanderburgh
Flora, Joseph O.	Indianapolis	Marion
Fodor, Oscar	Seattle, Wash.	Shelby
Folck, J. K.	Princeton	Gibson
Folkening, N. C.	Indianapolis	Marion
Foltz, Lloyd E.	Brownsburg	Hendricks
Forbes, Violet Crabbe	Wolcott	White
Foreman, Harry L.	Indianapolis	Marion
Foreman, Walter A.	Brookville	Fayette-Franklin
Forry, Frank	Indianapolis	Marion
Forsee, Norman E.	Jeffersonville	Clark
Forsyth, D. H.	Terre Haute	Vigo
Fosbrink, E. L.	Syracuse	Kosciusko
Fosgate, Harold L.	Cumberland	Marion
Foster, Lee N.	Indianapolis	Marion
Foster, Ray T.	New Castle	Henry
Fountaine, Thomas J.	Bedford	Lawrence
Fouts, Paul J.	Indianapolis	Marion
Fowler, Richard R.	Bloomington	Owen-Monroe
Fox, C. Philip	Washington	Daviess-Martin
Fox, Maurice S.	Vincennes	Knox
Fox, R. H. (H)	Bicknell	Knox
Foy, H. W.	Fort Wayne	Allen
Frank, J. R.	Valparaiso	Porter
Frank, L. L.	South Bend	St. Joseph
Franklin, William L.	Indianapolis	Marion
Frankowski, Clementine	Whiting	Lake
Frantz, Mount E.	Danville	Hendricks
Frasch, M. G.	Lafayette	Tippecanoe
Frash, De Von W.	South Bend	St. Joseph
Frazin, Bernard	Indianapolis	Marion
Freed, Carl A.	Attica	Fountain-Warren
Freed, James C.	Attica	Fountain-Warren
Freed, John E., Sr.	Terre Haute	Vigo
Freed, John E., Jr.	Terre Haute	Vigo
Freeman, F. M.	Goshen	Elkhart
French, Wm. G.	Evansville	Vanderburgh
Frey, William B.	South Bend	St. Joseph
Frey, Harley B.	Lafayette	Tippecanoe
Friedman, Isadore E.	Hammond	Lake
Friedman, Leo	Evansville	Vanderburgh

Name	City	County
Friedman, Morris S.	South Bend	St. Joseph
Friedrich, Louis M. (H)	Hobart	Lake
Frith, Gladys D.	South Bend	St. Joseph
Frith, Louis G.	South Bend	St. Joseph
Fritsch, L. E.	Evansville	Vanderburgh
Fromhold, Willis A.	Indianapolis	Marion
Frost, John W.	Indianapolis	Marion
Fruth, Rodney B.	Connersville	Fayette-Franklin
Fruth, Virgil T.	Connersville	Fayette-Franklin
Fry, Robert D.	Indianapolis	Marion
Frybarger, S. S.	Converse	Miami
Fullerton, R. L.	Indianapolis	Marion
Funk, John W.	Muncie	Delaware-Blackford
Funkhouser, A. G.	Indianapolis	Marion
Funkhouser, Elmer	Indianapolis	Marion
Fuqua, Harold B.	Terre Haute	Vigo
Furgason, Paul C.	Indianapolis	Marion
Furniss, S. A. (H)	Indianapolis	Marion
Fuson, W. J.	Greencastle	Putnam
	G	
Gaard, Richard C.	Evansville	Vanderburgh
Gabe, Wm. E.	Indianapolis	Marion
Gable, H. B.	Monticello	White
Gaddy, Euclid T.	Indianapolis	Marion
Galante, Vincent J.	Gary	Lake
Galbreath, R. S.	Huntington	Huntington
Galbreath, J. P.	Burnettsville	White
Galliher, Marjorie J.	Muncie	Delaware-Blackford
Gallup, Palmer R.	Indianapolis	Marion
Gambill, Wm. D.	Indianapolis	Marion
Gammieri, Robert L.	Indianapolis	Marion
Gannon, G. W.	Gary	Lake
Ganser, Richard A.	Mishawaka	St. Joseph
Gante, H. W.	Anderson	Madison
Ganz, Max	Marion	Grant
Garber, E. C.	Dunkirk	Jay
Garber, J. Neill	Indianapolis	Marion
Garber, Paul A.	South Whitley	Whitley
Garceau, George J.	Indianapolis	Marion
Gard, Daniel A.	Indianapolis	Marion
Gardiner, H. Glenn	East Chicago	Lake
Gardiner, Sprague H.	Indianapolis	Marion
Gardner, Buckman	Indianapolis	Marion
Gardner, M. D.	Michigan City	La Porte
Gardner, Russell A.	Michigan City	La Porte
Garfield, M. D.	Indianapolis	Marion
Garland, Edgar	Evansville	Vanderburgh
Garling, L. C.	Muncie	Delaware-Blackford
Garner, William (H)	Indianapolis	Marion
Garner, W. Stanley	Indianapolis	Marion
Garner, Wm. H.	New Albany	Floyd
Garrett, John D. (H)	Indianapolis	Marion
Garrett, Robert A.	Indianapolis	Marion
Garrison, James L.	Cumberland	Marion
Garrison, Leon J.	Gas City	Grant
Garton, H. W.	Ft. Wayne	Allen
Gaskill, Herbert S.	Indianapolis	Marion
Gastineau, F. M.	Indianapolis	Marion
Gatch, W. D.	Indianapolis	Marion
Gates, George E.	South Bend	St. Joseph
Gaul, L. Edward	Evansville	Vanderburgh
Gaunt, Everett W.	Alexandria	Madison
Gehres, R. W.	Shelbyville	Shelby
Geick, Raymond	Fort Branch	Gibson
Geider, Roy A.	Indianapolis	Marion
Geiger, Dillon	Bloomington	Owen-Monroe
Geisinger, L. N. (H)	Auburn	De Kalb
Geller, Samuel	Owensville	Gibson
Gentile, John P.	New Albany	Floyd
George, Charles L.	Indianapolis	Marion
Gerding, William J.	Fort Wayne	Allen
Gerrish, D. A.	Terre Haute	Vigo
Gerrish, W. D.	Clinton	Parke-Vermillion
Gery, Richard E.	Lafayette	Tippecanoe
Gessler, W. F.	Fort Wayne	Allen
Gevirtz, M. B.	Hammond	Lake
Gibbs, Charles (H)	Greenfield	Hancock
Gibbs, Joseph W.	Danville	Hendricks
Gibson, Greta	Indianapolis	Marion
Gick, Herman	Indianapolis	Marion
Gifford, F. E.	Indianapolis	Marion
Gilbert, Ivan	Terre Haute	Vigo
Gilkison, John S.	Shoals	Daviess-Martin
Gill, Bernard P.	Evansville	Vanderburgh
Gill, Dee Dar	Greenfield	Hancock
Gill, Thomas A.	Muncie	Delaware-Blackford
Gillespie, Chas. E.	Seymour	Jackson
Gillespie, Chas. F.	Indianapolis	Marion
Gillespie, G. R.	Brownstown	Jackson
Gillespie, J. E.	Indianapolis	Marion
Gillespie, J. F. (H)	Greencastle	Putnam
Gillette, Walter R.	Bluffton	Wells
Gilliatt, J. P.	Salem	Washington
Gillum, John R.	Terre Haute	Vigo
Gilman, M. M.	South Bend	St. Joseph
Gilmore, R. A.	Michigan City	La Porte
Gilmore, Robert W.	Michigan City	LaPorte
Gingerick, Chas. M.	Liberty Center	Wells
Ginsberg, Stewart	Marion	Grant
Giordano, A. S.	South Bend	St. Joseph
Girod, Arthur H.	Decatur	Adams
Gish, Howard M.	Brookston	White
Gitlin, Max M.	Bluffton	Wells
Gitlin, Wm. A.	Bluffton	Wells
Givner, David	Indianapolis	Marion
Glackman, J. C., Jr.	Rockport	Spencer
Glackman, J. C., Sr.	Rochester	Fulton
Gladstone, N. H.	Fort Wayne	Allen
Glaser, Robert E.	Brookville	Fayette-Franklin
Glass, R. L.	Indianapolis	Marion
Glendening, J. L.	Indianapolis	Marion
Glenn, Fred C.	Tell City	Perry
Glenn, L. F.	Ramsey	Harrison
Glock, H. E.	Fort Wayne	Allen
Glock, M. E.	Ft. Wayne	Allen
Glock, Wayne R.	Ft. Wayne	Allen
Glosson, Jack R.	Clay City	Clay
Gobbel, N. E.	English	Crawford
Goebel, Carl W.	Fort Wayne	Allen
Godersky, George E.	South Bend	St. Joseph
Goethals, Charles J.	Mishawaka	St. Joseph
Goldberg, Harold B.	Gary	Lake
Goldman, Samuel	Indianapolis	Marion
Goldstone, Adolph	Gary	Lake
Goldstone, Joseph	Gary	Lake
Goldstone, S. R.	Gary	Lake
Good, R. P.	Kokomo	Howard
Goodman, Eli	Charlestown	Clark
Goodman, H. T.	Terre Haute	Vigo
Goodwin, C. B. (H)	Kendallville	Noble
Goraczewski, Thaddeus	South Bend	St. Joseph
Gordin, Stanley	Connersville	Fayette-Franklin
Gordin, Stanton E. (H)	Connersville	Fayette-Franklin
Gordon, Joseph L.	Wheeler	Porter
Gordon, J. M.	South Bend	St. Joseph
Gorton, Mary L.	Gary	Lake
Gosman, James H.	Indianapolis	Marion
Gossard, Meredith B.	Tipton	Tipton
Gossom, Donn R.	Terre Haute	Vigo
Gotlib, Milton H.	Indianapolis	Marion
Gould, L. K.	Ft. Wayne	Allen
Govorchin, Alexander	East Chicago	Lake
Graessle, Harold P.	Seymour	Jackson

Name	City	County
Graf, John P.	Indianapolis	Marion
Graf, Jerome A.	Bloomfield	Greene
Graham, George M.	Ft. Wayne	Allen
Graham, Thomas	Lafayette	Tippecanoe
Grant, Benjamin F.	Gary	Lake
Grant, John H.	Evansville	Vanderburgh
Graves, J. W.	Indianapolis	Marion
Graves, Noel S.	Vevay	Switzerland
Graves, Orville M.	Princeton	Gibson
Gray, Clyde C.	Cloverdale	Putnam
Gray, D. E.	Crown Point	Lake
Gray, Leon	Martinsville	Morgan
Gray, Paul M.	Huntington	Huntington
Grayston, F. W. (H)	Huntington	Huntington
Grayston, Wallace S.	Huntington	Huntington
Green, Carl L.	Vincennes	Knox
Green, F. H., Jr.	Rushville	Rush
Green, George F.	South Bend	St. Joseph
Green, John H.	North Vernon	Jennings
Green, Myron H.	Indianapolis	Marion
Green, Norval E.	South Bend	St. Joseph
Green, Oscar	Indianapolis	Marion
Green, S. I.	St. Bernice	Parke-Vermillion
Green, Wm. L. (H)	Pekin	Washington
Greenburg, Rolland	Jasper	Dubois
Greene, Claude D.	Spencer	Owen-Monroe
Greene, Frederick G.	Bloomingdale	Parke-Vermillion
Greene, Wm. R.	Henryville	Clark
Gregg, Albert F.	Connersville	Fayette-Franklin
Gregg, Edwin E.	Thorntown	Boone
Gregoline, A. F.	Gary	Lake
Greiber, Marvin F.	Muncie	Delaware-Blackford
Greip, Arthur H.	Evansville	Vanderburgh
Greisen, Jack G.	Whiting	Lake
Greist, H. W. (H)	Monticello	White
Greist, John	Indianapolis	Marion
Griffin, J. P.	Chesterton	Porter
Griffis, V. C.	Richmond	Wayne-Union
Griffith, Harold	Vevay	Switzerland
Griffith, James W.	Sheridan	Hamilton
Griffith, R. E.	Indianapolis	Marion
Griffith, Richard S.	Indianapolis	Marion
Grillo, Donald	South Bend	St. Joseph
Grimes, J. H.	Martinsville	Morgan
Grisell, Ted L.	Indianapolis	Marion
Griswold, W. R.	Mare Island, Calif.	Marion
Groman, Herman C.	Hammond	Lake
Grossman, W. L.	North Vernon	Jennings
Grosso, W. G.	East Chicago	Lake
Grotts, Bruce F.	Michigan City	LaPorte
Grove, Robert H.	Rossville	Clinton
Gullett, Charles C.	Union City	Randolph
Gunderson, Shaun D.	Indianapolis	Marion
Gustafson, G. W.	Indianapolis	Marion
Gustafson, Milton	Muncie	Delaware-Blackford
Gustaitis, John W.	East Chicago	Lake
Gutelius, C. B.	Indianapolis	Marion
Guthrie, F. C.	Anderson	Madison
Gutierrez, F. A.	Gary	Lake
Gutstein, Richard R.	Kendallville	Noble
Gwaltney, L. F.	Roachdale	Putnam
Gwin, Merle D.	Miami Beach, Fla.	Jasper-Newton

H

Habegger, Myron L.	Berne	Adams
Habich, Carl	Indianapolis	Marion
Hack, E. C.	Hammond	Lake
Hadden, Claude	Indianapolis	Marion
Hade, Frederick L.	Bridgeport	Marion
Hadley, David	Indianapolis	Marion
Hadley, Harvey	Richmond	Wayne-Union
Hadley, Murray N. (H)	Indianapolis	Marion
Haffner, H. G.	Ft. Wayne	Allen
Haggard, E. B.	Indianapolis	Marion
Hagie, F. E.	Richmond	Wayne-Union
Hahn, E. V.	Indianapolis	Marion
Haley, Paul E.	South Bend	St. Joseph
Halfast, Richard W.	Kokomo	Howard
Hall, Bernard R.	Logansport	Cass
Hall, E. H.	Dunkirk	Jay
Hall, Frank M.	Indianapolis	Marion
Hall, Jack R.	Indianapolis	Marion
Hall, James M.	South Bend	St. Joseph
Hall, Orville A.	Muncie	Delaware-Blackford
Hall, Thomas C.	Chesterton	Porter
Hallam, F. T.	Indianapolis	Marion
Halleck, H. J.	Winamac	Pulaski
Haller, Robert L.	Fort Wayne	Allen
Haller, Thomas C.	Crawfordsville	Montgomery
Hamer, Homer G.	Indianapolis	Marion
Hamilton, Antha A.	Shelburn	Sullivan
Hamilton, Charles O.	South Bend	St. Joseph
Hamilton, Emory D.	Ft. Wayne	Allen
Hamilton, Guy (H)	Madison	Jefferson
Hamilton, J. R.	Mitchell	Lawrence
Hamilton, M. Luther	Newberry	Greene
Hamilton, Orville G.	Bluffton	Wells
Hamilton, Robert C.	East Chicago	Lake
Hammel, Howard T.	Bedford	Lawrence
Hammer, Jay Wm.	Middletown	Henry
Hammersley, Geo. K.	Frankfort	Clinton
Hammond, Keith	Paoli	Orange
Hammond, R. Case	Evansville	Vanderburgh
Hammond, Stanley M.	Portland	Jay
Hampshire, Don R.	Indianapolis	Marion
Hancock, John G.	Indianapolis	Marion
Hanley, Edward J.	Indianapolis	Marion
Hanna, Duke	Red Key	Jay
Hanna, T. A.	Indianapolis	Marion
Hannah, Jack W.	Wakarusa	Elkhart
Hansell, R. M.	Indianapolis	Marion
Hansen, A. H.	Hammond	Lake
Hanson, Martin F.	Elwood	Madison
Harcourt, A. K.	Indianapolis	Marion
Harden, Murray E.	Lafayette	Tippecanoe
Hardin, W. E.	Ossian	Wells
Harding, M. Richard	Indianapolis	Marion
Harding, Myron S.	Indianapolis	Marion
Hardtke, Eldred F.	Bloomington	Owen-Monroe
Hardy, John J.	North Liberty	St. Joseph
Hare, Daniel M.	Evansville	Vanderburgh
Hare, E. H.	Indianapolis	Marion
Hare, John H.	Evansville	Vanderburgh
Hare, Laura	Indianapolis	Marion
Hargan, Jack L.	Indianapolis	Marion
Harger, Robert W.	Indianapolis	Marion
Harkcom, H. E.	St. Paul	Decatur
Harkness, R. G.	Terre Haute	Vigo
Harlan, William	Ligonier	Noble
Harless, Clarence M.	Chesterton	Porter
Harmon, C. J.	Richmond	Wayne-Union
Harmon, Gladys H.	Richmond	Wayne-Union
Harmon, Vachelle E.	South Bend	St. Joseph
Harmon, Wayne	Lynn	Randolph
Harold, A. H.	Indianapolis	Marion
Harold, N. E. (H)	Indianapolis	Marion
Harris, Carl B.	Indianapolis	Marion
Harris, Donald M.	Gary	Lake
Harris, Paul N.	Indianapolis	Marion
Harris, R. F.	Noblesville	Hamilton
Harris, Wm. Lee	Evansville	Vanderburgh
Harrison, B. L.	New Castle	Henry

Name	City	County
Harshman, L. P.	Ft. Wayne	Allen
Harshman, Martin L.	Lafayette	Tippecanoe
Harstad, Casper	Rockville	Parke-Vermillion
Hart, L. Paul	University City, Mo.	Vanderburgh
Hart, Robert B.	Columbus	Bartholomew-Brown
Hart, Wm. D.	Anderson	Madison
Harter, Eli Blair	Lafayette	Tippecanoe
Hartley, C. A., Jr.	Evansville	Vanderburgh
Hartman, John	Angola	Steuben
Hartz, F. Minton	Evansville	Vanderburgh
Harvey, Harry C.	Ft. Wayne	Allen
Harvey, R. J.	Zionsville	Boone
Harvey, Verne K.	Alexandria, Va.	Marion
Hasewinkle, A. M.	Ft. Wayne	Allen
Hasewinkel, Carroll	Indianapolis	Marion
Hash, John S.	Noblesville	Hamilton
Haslem, Ezra R.	Terre Haute	Vigo
Haslem, John R.	Terre Haute	Vigo
Hasler, Norman B.	Indianapolis	Marion
Haslinger, C. J.	Indianapolis	Marion
Hastings, Warren C.	Ft. Wayne	Allen
Hatfield, B. F.	Indianapolis	Marion
Hatfield, Jack J.	Indianapolis	Marion
Hatfield, N. W.	Indianapolis	Marion
Hathaway, Clayton B.	Butler	DeKalb
Hattendorf, A. P.	Ft. Wayne	Allen
Haugseth, Ellsworth K.	South Bend	St. Joseph
Hauss, Augustus P.	New Albany	Floyd
Havens, Oscar	Cicero	Hamilton
Havens, R. E.	Ft. Wayne	Allen
Havice, Jay F.	Lake Lure, N. C.	Allen
Hawes, J. K. (H)	Columbus	Bartholomew-Brown
Hawes, M. E.	Columbus	Bartholomew-Brown
Hawk, James H.	Indianapolis	Marion
Hayes, Jess D.	East Chicago	Lake
Hayes, T. R.	Muncie	Delaware-Blackford
Haymond, George N.	Warsaw	Kosciusko
Haymond, Joseph L.	Indianapolis	Marion
Hays, Everett L.	Indianapolis	Marion
Hays, George R.	Richmond	Wayne-Union
Hazinski, R. T.	Griffith	Lake
Headley, L. M.	Lebanon	Boone
Heard, Albert	Evansville	Vanderburgh
Heberer, J. M.	Evansville	Vanderburgh
Heck, Martin C.	Jasper	Dubois
Heck, Rolfe A.	College Corner, Ohio	Wayne-Union
Hedde, E. L.	Logansport	Cass
Hedgcock, R. A.	Frankfort	Clinton
Hedrick, James T.	Gary	Lake
Hedrick, Philip W.	Indianapolis	Marion
Hefti, Karl R.	Evansville	Vanderburgh
Heilman, W. C.	New Castle	Henry
Heinrich, Weston A.	Evansville	Vanderburgh
Heinz, Dorothy C. V.	Indianapolis	Marion
Held, George A.	Jasper	Dubois
Heller, N. L.	Dunkirk	Jay
Heller, Oscar (H)	Greenfield	Hancock
Helmen, H. W.	South Bend	St. Joseph
Henderson, Arvin	Ridgeville	Randolph
Henderson, Francis G.	Indianapolis	Marion
Henderson, N. C.	Michigan City	LaPorte
Henderson, R. A.	Muncie	Delaware-Blackford
Hendricks, John D. (H)	Indianapolis	Marion
Hendricks, John W.	Indianapolis	Marion
Hendrix, Claude	Waveland	Montgomery
Hennessee, Philip C.	Indianapolis	Marion
Henning, Carl	Hanover	Jefferson
Henry, Alvin L.	Columbus	Bartholomew-Brown
Henry, Howard J.	Knox	Starke
Henry, Russell S.	Indianapolis	Marion
Hensler, B. M.	Anderson	Madison
Hepburn, C. K.	Indianapolis	Marion
Hepner, H. S.	Bloomington	Owen-Monroe
Herd, Cloyn R.	Peru	Miami
Herendeen, E. V.	Rochester	Fulton
Heritier, C. Jules	Columbia City	Whitley
Herr, John W.	Mt. Vernon	Posey
Herrick, C. L.	Akron	Fulton
Herring, G. N.	Pierceton	Kosciusko
Herrmann, Gordon T.	Evansville	Vanderburgh
Herrold, G. W.	Lafayette	Tippecanoe
Hershey, E. A.	Churubusco	Whitley
Herzer, C. C.	Evansville	Vanderburgh
Hess, Paul P.	New Albany	Floyd
Hetherington, A. M.	Indianapolis	Marion
Hetherington, John A.	Indianapolis	Marion
Hetman, Mitchell J.	Westville	LaPorte
Heubi, John E.	Indianapolis	Marion
Hewitt, M. I.	South Bend	St. Joseph
Hiatt, R. L.	Ft. Wayne	Allen
Hibner, Nolan A.	Monticello	White
Hickman, A. Lee	Hammond	Lake
Hickman, Walter	Indianapolis	Marion
Hicks, Joseph (H)	Arcadia	Hamilton
Hiestand, H. J.	Pennville	Jay
Higgins, James L.	Petersburg	Pike
Higgins, John R.	New Albany	Floyd
High, Ralph L.	Muncie	Delaware-Blackford
Hilbert, John W.	South Bend	St. Joseph
Hildebrand, W. O.	Topeka	LaGrange
Hill, H. D.	Richmond	Wayne-Union
Hill, H. E.	Muncie	Delaware-Blackford
Hill, Kenneth G.	New Castle	Henry
Hill, Paul G.	Cambridge City	Wayne-Union
Hill, Robert	Muncie	Delaware-Blackford
Hill, T. N.	Scottsburg	Scott
Hilldrup, Don G	Indianapolis	Marion
Hillenbrand, Charles	Michigan City	LaPorte
Hillery, John L.	Warsaw	Kosciusko
Hillis, L. J.	Logansport	Cass
Hillman, Marion W.	South Bend	St. Joseph
Hillman, W. H. (H)	South Bend	St. Joseph
Himebaugh, Gilbert	Veedersburg	Fountain-Warren
Himebaugh, J. R. S.	Indianapolis	Marion
Himler, James M.	Indianapolis	Marion
Hinchman, C. P.	Geneva	Adams
Hinchman, Jean F.	Parker	Randolph
Hine, U. B.	Indianapolis	Marion
Hines, A. V.	Auburn	DeKalb
Hines, Don C.	Indianapolis	Marion
Hippensteel, Harland	Auburn	DeKalb
Hippensteel, R. R.	Indianapolis	Marion
Hippensteele, Ralph	Fremont	Steuben
Hisrich, L. W.	Batesville	Ripley
Hobbs, Arthur	Evansville	Vanderburgh
Hochhalter, Marian	Logansport	Cass
Hodges, Fletcher	Indianapolis	Marion
Hodges, Wm. A.	Oaktown	Knox
Hodgin, Phillip	Orleans	Orange
Hodurski, Zigfield	Gary	Lake
Hoeger, H. R.	Brookville	Fayette-Franklin
Hoffman, A. F.	Ft. Wayne	Allen
Hoffman, Curtis R.	Richmond	Wayne-Union

Name	City	County
Hoffman, Doris	Vincennes	Knox
Hoffman, Herman	Hartford City	Delaware-Blackford
Hoffman, R. V.	South Bend	St. Joseph
Hoffman, Robert V., Jr.	Chicago, Ill.	St. Joseph
Hoffmann, S. P., Sr.	Ft. Wayne	Allen
Hofmann, Andrew	Hammond	Lake
Hofmann, J. Wm.	Indianapolis	Marion
Hogle, Frank D.	Logansport	Cass
Holdeman, Lillian	South Bend	St. Joseph
Holdeman, R. W.	South Bend	St. Joseph
Holladay, L. J.	Lafayette	Tippecanoe
Holland, Chas. E.	Bloomington	Owen-Monroe
Holland, D. J.	Bloomington	Owen-Monroe
Holland, Philip	Bloomington	Owen-Monroe
Holliday, L. D.	Fairmount	Grant
Hollingsworth, A. A.	Indianapolis	Marion
Hollingsworth, Marshall P. (H)	Princeton	Gibson
Hollis, Walter H.	Ft. Branch	Gibson
Holloway, W. A. (H)	Logansport	Cass
Holman, J. E., Sr.	Indianapolis	Marion
Holman, J. E., Jr.	Indianapolis	Marion
Holmes, Claude D.	Indianapolis	Marion
Holmes, Claude D., Sr.	Frankfort	Clinton
Holmes, G. W.	Gary	Lake
Holmes, W. W.	Logansport	Cass
Holsinger, R. E.	Ft. Wayne	Allen
Holtzendorf, C. E. (H)	St. Petersb'g, Fla.	Marshall
Holtzman, Paul W.	Indianapolis	Marion
Honan, Paul R.	Lebanon	Boone
Hood, Ainslee A.	Indianapolis	Marion
Hooke, Sam W.	Noblesville	Hamilton
Hoopes, Jane	Evansville	Vanderburgh
Hoover, D. A.	Terre Haute	Vigo
Hoover, J. Guy	Minneapolis, Minn.	Warrick
Hoover, J. J.	Terre Haute	Vigo
Hoover, Peter B.	Boonville	Warrick
Hopkins, J. R.	Hammond	Lake
Hopkins, Lester H.	Versailles	Ripley
Hoppenrath, Wesley M.	Elwood	Madison
Hoppenrath, Wm. (H)	Elwood	Madison
Horst, William N.	Crown Point	Lake
Horswell, R. G.	Bristol	Elkhart
Horwitz, Thomas	Indianapolis	Marion
Horton, George R.	Ft. Wayne	Allen
Hostetler, Carl M.	Goshen	Elkhart
Hostetter, Irwin S.	Muncie	Delaware-Blackford
Houser, D. Stanley	Lakeville	St. Joseph
Houser, Wayne W.	Monon	White
Houseworth, John H.	Indianapolis	Marion
Houston, Fred D.	Lawrenceburg	Dearborn-Ohio
How, John T. (H)	Lakeville	St. Joseph
How, Louis E.	South Bend	St. Joseph
Howard, W. H.	Hammond	Lake
Howe, Fordyce L.	Ft. Wayne	Allen
Howell, Joseph D.	Indianapolis	Marion
Howell, R. D.	Indianapolis	Marion
Hoyt, Lester H.	Indianapolis	Marion
Huber, Carl P.	Indianapolis	Marion
Huckleberry, Carl D.	Cloverdale	Putnam
Huckleberry, Irvin	Salem	Washington
Hudson, Foster J.	Indianapolis	Marion
Huff, A. D.	Marion	Grant
Huffman, A. D.	Acton	Marion
Huffman, V. P.	South Whitley	Whitley
Hughes, Richard R.	Lafayette	Tippecanoe
Hughes, W. F. (H)	Indianapolis	Marion
Huggins, Victor S.	Evansville	Vanderburgh
Hull, A. W.	Elkhart	Elkhart
Hull, James E.	Indianapolis	Marion
Hull, Ronald H.	Portsmouth, Va.	Marion
Hummel, R. M.	Marion	Grant
Hummons, Henry L.	Indianapolis	Marion
Humphrey, Paul E.	Terre Haute	Vigo
Humphreys, Joe E.	Vincennes	Knox
Humphreys, John W.	Crawfordsville	Montgomery
Hunn, M. F.	Elkhart	Elkhart
Hunsberger, W. G.	Lafayette	Tippecanoe
Hunt, Edgar J.	Terre Haute	Vigo
Hunt, Gayle J.	Richmond	Wayne-Union
Hunter, F. P.	Lafayette	Tippecanoe
Hunter, Lowell G.	Milan	Ripley
Huoni, J. S.	Jeffersonville	Clark
Hupe, Charles (H)	Lafayette	Tippecanoe
Hurley, Anson	Muncie	Delaware-Blackford
Hurley, John R.	Daleville	Delaware-Blackford
Hursey, Virgil G.	Milford	Kosciusko
Hurt, L. B.	Indianapolis	Marion
Huse, William M.	Indianapolis	Marion
Husted, Robert	Hammond	Lake
Hutcheson, W. R. (H)	Greencastle	Putnam
Hutchison, Donald R.	Fountain City	Wayne-Union
Hutto, W. H.	Kokomo	Howard
Hyatt, Gilbert T.	Evansville	Vanderburgh
Hyde, Carroll	South Bend	St. Joseph
Hynes, Roy T.	Indianapolis	Marion

I

Iddings, J. W.	Crown Point	Lake
Ikins, R. G.	Lafayette	Tippecanoe
Imhof, Joseph D.	Muncie	Delaware-Blackford
Ingwell, Guy B.	Knox	Starke
Inlow, Herbert	Shelbyville	Shelby
Inlow, W. D.	Shelbyville	Shelby
Irey, P. R.	Plymouth	Marshall
Irish, Wilbur J.	East Chicago	Lake
Irwin, Glenn W., Jr.	Indianapolis	Marion
Irwin, Seth	Summitville	Madison
Iske, Paul G.	Indianapolis	Marion
Isler, N. C.	Jeffersonville	Clark
Iterman, G. E.	New Castle	Henry
Ives, R. J.	Francesville	Pulaski

J

Jackson, Dean B.	Hartford City	Delaware-Blackford
Jackson, F. E.	Indianapolis	Marion
Jackson, James W.	Indianapolis	Marion
Jackson, John F.	Fort Wayne	Allen
Jackson, J. K.	Aurora	Dearborn-Ohio
Jackson, Jesse L.	Indianapolis	Marion
Jacobs, H. A.	Indianapolis	Marion
Jaeger, A. S.	Indianapolis	Marion
James, N. A.	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jannasch, Maurice C.	Gary	Lake
Jaquith, O. S. (H)	Indianapolis	Marion
Jarrett, Paul E.	Anderson	Madison
Jay, Arthur N.	Indianapolis	Marion
Jeffress, Jessie E.	Gary	Lake
Jeffries, K. I.	Indianapolis	Marion
Jenkins, Robert E.	Indianapolis	Marion
Jennings, Frank	Indianapolis	Marion
Jewell, Earl B.	Logansport	Cass
Jewell, George M.	Kokomo	Howard
Jewett, Joe H.	Indianapolis	Marion
Jewett, Laurence (H)	Indianapolis	Marion
Jewett, Robert E.	Indianapolis	Marion
Jinks, C. H.	Indianapolis	Marion
Jinnings, Loren E.	Garrett	DeKalb
Jobes, James E.	Indianapolis	Marion

Name	City	County
Jobes, N. E. (H)	Indianapolis	Marion
Joest, Charles O.	Mishawaka	St. Joseph
Johantgen, Harold N.	Indianapolis	Marion
Johns, D. R.	East Chicago	Lake
Johns, Elmer	Zionsville	Boone
Johns, N. C.	South Bend	St. Joseph
Johnson, C. E.	Rensselaer	Jasper-Newton
Johnson, Earl E.	Covington	Fountain-Warren
Johnson, F. D.	Waynetown	Montgomery
Johnson, G. C. (H)	Evansville	Vanderburgh
Johnson, George M.	Richmond	Wayne-Union
Johnson, Herbert S.	Lafayette	Tippecanoe
Johnson, James B.	Greencastle	Putnam
Johnson, J. J. (H)	Milltown	Crawford
Johnson, Lonnie B.	Gary	Lake
Johnson, Lowell R.	Lafayette	Tippecanoe
Johnson, M. H. C.	Vincennes	Knox
Johnson, Owen	Peru	Miami
Johnson, Paul Dewey	Terre Haute	Vigo
Johnson, Paul S.	Richmond	Wayne-Union
Johnson, R. B.	Rushville	Rush
Johnson, S. L.	Evansville	Vanderburgh
Johnson, Thomas W.	Indianapolis	Marion
Johnson, W. A.	Perrysville	Parke-Vermillion
Johnson, Wm. F.	Indianapolis	Marion
Johnston, Alan	Plainfield	Hendricks
Johnston, D. D.	Indianapolis	Marion
Johnston, Robert L.	Bluffton	Wells
Johnston, R. G.	Huntington	Huntington
Jolly, Lewis E.	Madison	Jefferson
Jolly, W. P.	Richland	Spencer
Jones, Albert T.	Anderson	Madison
Jones, Charles A.	Franklin	Johnson
Jones, Clifford M.	Whiting	Lake
Jones, D. D. (H)	Berne	Adams
Jones, David	Lafayette	Tippecanoe
Jones, David E.	Indianapolis	Marion
Jones, E. S.	Hammond	Lake
Jones, Francis P.	Indianapolis	Marion
Jones, George	Wanamaker	Marion
Jones, H. E.	Anderson	Madison
Jones, John C.	LaPorte	LaPorte
Jones, John Carl	Logansport	Cass
Jones, King Solomon	Michigan City	LaPorte
Jones, R. B.	LaPorte	LaPorte
Jones, W. W.	Frankfort	Clinton
Jordan, Leo E.	Lynn	Randolph
Joseph, Rex M.	Indianapolis	Marion
Jurgensen, Walter T.	Ft. Wayne	Allen
Justin, Jerome W.	Hammond	Lake

K

Kabel, Robert N.	Terre Haute	Vigo
Kahan, H. L.	Gary	Lake
Kahler, M. V.	Indianapolis	Marion
Kahn, Alexander J.	Indianapolis	Marion
Kahn, Howard L.	Indianapolis	Marion
Kalb, Everett L.	Indianapolis	Marion
Kaler, James	Plymouth	Marshall
Kamm, Bernard A.	South Bend	St. Joseph
Kamman, G. H. (H)	Seymour	Jackson
Kammen, Leo	Indianapolis	Marion
Kammen, Robert	Indianapolis	Marion
Kammer, Grace C.	Muncie	Delaware-Blackford
Kammer, Walter F.	Muncie	Delaware-Blackford
Kantzer, Floyd B.	Garrett	De Kalb
Kaplan, Benjamin B.	East Chicago	Lake
Karberg, Richard J.	Lafayette	Tippecanoe
Karn, John W.	South Bend	St. Joseph
Karol, Herbert J.	Indianapolis	Marion
Karpel, Bernard	Mooresville	Morgan
Karsell, W. A.	Bloomington	Owen-Monroe
Kasting, Gerald E.	Indianapolis	Marion
Katterjohn, James C.	Indianapolis	Marion
Kauffman, Harley M.	Evansville	Vanderburgh
Kauffman, Nelson N.	Indianapolis	Marion
Kauffman, Sidney A.	Indianapolis	Marion
Kay, Oran	Spencer	Owen-Monroe
Keck, Carleton A.	Fort Wayne	Allen
Keefe, Thomas L.	Logansport	Cass
Keeling, F. E.	Portland	Jay
Keeling, J. E. (H)	Waldron	Shelby
Keenan, R. L.	Indianapolis	Marion
Keever, C. H.	Indianapolis	Marion
Keiser, V. D.	Indianapolis	Marion
Keith, F. E. (H)	St. Bernice	Parke-Vermillion
Kelley, Clement E.	Indianapolis	Marion
Kelly, Don E.	Indianapolis	Marion
Kelly, Frank	Argos	Marshall
Kelly, J. F.	Indianapolis	Marion
Kelly, J. N.	LaPorte	La Porte
Kelly, W. C.	Anderson	Madison
Kelly, W. R.	Goshen	Elkhart
Kelly, Walter F. (H)	Indianapolis	Marion
Kelly, William M.	Indianapolis	Marion
Kelsey, L. E.	Kewanna	Fulton
Kelsey, Robert M.	LaPorte	La Porte
Kemp, John T.	Michigan City	La Porte
Kemp, M. W.	Madison	Jefferson
Kemp, W. A.	Connersville	Fayette-Franklin
Kemper, A. T. (H)	Muncie	Delaware-Blackford
Kempf, G. F.	Indianapolis	Marion
Kendall, F. M.	Nappanee	Elkhart
Kendrick, Frank J.	Gary	Lake
Kendrick, W. M.	Indianapolis	Marion
Kennedy, Eva	Camden	Carroll
Kennedy, Hall	Indianapolis	Marion
Kennedy, H. F.	Indianapolis	Marion
Kennedy, R. O.	Rushville	Rush
Kennedy, W. U.	New Castle	Henry
Kenoyer, Wilbur L.	Indianapolis	Marion
Kent, J. A.	Mulberry	Clinton
Kent, Richard N.	Ft. Wayne	Allen
Kenyon, C. E.	Cambridge City	Wayne-Union
Kepler, R. W.	La Porte	La Porte
Kercheval, John M.	Clinton	Parke-Vermillion
Kern, C. B. (H)	Muncie	Delaware-Blackford
Kern, C. G.	Lebanon	Boone
Kerr, Donald M.	Bedford	Lawrence
Kerr, Harry R.	Indianapolis	Marion
Kerrigan, R. L.	Michigan City	La Porte
Kerrigan, William F.	Rockport	Spencer
Keseric, Nicholas E.	French Lick	Orange
Kessler, Robert B.	Evansville	Vanderburgh
Ketcham, Jane M.	Indianapolis	Marion
Ketcham, John S.	Rossville	Clinton
Kidd, James G.	Roann	Wabash
Kidder, J. J. (H)	Salamonia	Jay
Kidder, Orva T.	Ft. Wayne	Allen
Kiechle, Frederick L.	Evansville	Vanderburgh
Kilgore, Byron, Jr.	Indianapolis	Marion
Kim, Young D.	Beech Grove	Marion
Kime, Charles E.	Richmond	Wayne-Union
Kime, E. N.	Indianapolis	Marion
Kime, J. T. (H)	Petersburg	Pike
Kindell, H. D.	New Richmond	Montgomery
King, Dale	Fairmount	Grant
King, Everett A.	Elizabeth City, N.C.	Crawford
King, James R.	Silver Lake	Kosciusko

Name	City	County
King, Joseph W.	Anderson	Madison
King, M. O.	Rochester	Fulton
King, P. C.	Swayzee	Grant
King, Robert W.	Cedar Lake	Lake
King, William E.	Indianapolis	Marion
King, William F.	Indianapolis	Marion
Kingsbury, J. K.	Indianapolis	Marion
Kinnaman, H. A.	Crawfordsville	Montgomery
Kinneman, R. E.	Greenfield	Hancock
Kintner, Burton E.	Elkhart	Elkhart
Kinzel, Robert J. W.	Indianapolis	Marion
Kinzie, M. Dale	Goshen	Elkhart
Kirch, L. N.	Evansville	Vanderburgh
Kirkhoff, Paul J.	Indianapolis	Marion
Kirklin, Oren L.	Indianapolis	Marion
Kirshman, F. E.	Muncie	Delaware-Blackford
Kirtley, J. M.	Crawfordsville	Montgomery
Kirtley, William R.	Indianapolis	Marion
Kiser, E. F.	Indianapolis	Marion
Kissinger, Charles C.	Fort Wayne	Marion
Kissinger, K. L.	Angola	Steuben
Kistler, James J.	La Porte	La Porte
Kistner, Arthur W.	Elkhart	Elkhart
Kistner, John W.	Elkhart	Elkhart
Kitterman, Harry E.	Indianapolis	Marion
Klahr, Elsworth	Indianapolis	Marion
Klain, B. V.	Indianapolis	Marion
Klamer, Charles H.	Jasper	Dubois
Klaus, J. M.	Crown Point	Lake
Kleifgen, William A.	Indianapolis	Marion
Kleindorfer, R. L.	Evansville	Vanderburgh
Kleinman, F. J.	Hebron	Porter
Klepinger, H. E.	Lafayette	Tippecanoe
Kling, Victor F.	Michigan City	La Porte
Klingler, Maurice O.	Plymouth	Marshall
Knapp, Arthur L.	South Bend	St. Joseph
Kneidel, John H.	Indianapolis	Marion
Knepple, L. R. (H)	Kokomo	Howard
Knode, Kenneth T.	South Bend	St. Joseph
Knowles, Charles Y.	Indianapolis	Marion
Knoy, Norris	Gary	Lake
Ko, Richard	Eaton	Delaware-Blackford
Kobrak, H. G.	Chicago, Ill.	Lake
Kobrin, Meyer W.	Gary	Lake
Koch, Elmer L.	Danville	Hendricks
Koehler, Elmer G.	Elkhart	Elkhart
Kohlstaedt, George	Indianapolis	Marion
Kohlstaedt, Karl C.	Indianapolis	Marion
Kohlstaedt, K. G.	Indianapolis	Marion
Kohne, C. J.	Decatur	Adams
Kohrman, Benj. M.	Michigan City	La Porte
Kolanko, Leon A.	Hammond	Lake
Kolettis, George J.	Gary	Lake
Komoroske, J. E.	East Chicago	Lake
Koons, Karl M.	Indianapolis	Marion
Koontz, William A.	Gas City	Grant
Kopanko, Bernard F.	East Chicago	Lake
Kopcha, Joseph E.	Gary	Lake
Kopecky, Robert R.	Indianapolis	Marion
Kopp, Herschel S.	Santa Barbara, Calif.	Marion
Kopp, O. A.	Anderson	Madison
Koransky, David S.	Hammond	Lake
Korn, Jerome M.	Gary	Lake
Kornafel, L. H.	Indianapolis	Marion
Kraft, Bennett	Indianapolis	Marion
Kraft, Haldon C.	Noblesville	Hamilton
Kramer, A. A.	South Bend	St. Joseph
Kraning, Kenneth	Kewanna	Fulton
Kratz, Paul E.	Columbia City	Whitley
Kratzer, E. F.	Kokomo	Howard
Kresler, Leon	Rensselaer	Jasper-Newton
Kress, James W.	Michigan City	La Porte
Kretsch, R. W.	Hammond	Lake
Krieble, Wm. W.	Terre Haute	Vigo
Krieger, George M.	Michigan City	La Porte
Kron, R. Vincent	East Gary	Lake
Krueger, Frederick W.	Richmond	Wayne-Union
Krueger, John E.	Indianapolis	Marion
Kruse, E. H.	Fort Wayne	Allen
Kruse, Walter E.	Fort Wayne	Allen
Kubik, Francis J.	Michigan City	La Porte
Kubley, James D.	Plymouth	Marshall
Kudele, L. T.	Whiting	Lake
Kuder, Howard V.	Muncie	Delaware-Blackford
Kuhn, Frederick L.	South Bend	St. Joseph
Kuhn, Hedwig S.	Hammond	Lake
Kuhn, Hugh A.	Hammond	Lake
Kuhn, R. W.	Wilkinson	Hancock
Kunkler, Joseph	Terre Haute	Vigo
Kunkler, Wm. C.	Terre Haute	Vigo
Kuntz, Herman W.	Indianapolis	Marion
Kurtz, Fred B.	Indianapolis	Marion
Kurtz, Philip L.	Indianapolis	Marion
Kurtz, William A.	Tipton	Tipton
Kwitny, I. J.	Indianapolis	Marion

L

LaBier, C. Russell	Terre Haute	Vigo
LaBier, Clarence R. (H)	Terre Haute	Vigo
Ladig, Donald S.	Fort Wayne	Allen
LaDine, C. B.	Indianapolis	Marion
LaDuron, Jules F.	Muncie	Delaware-Blackford
LaFollette, Forrest R.	Whiting	Lake
LaFollette, Robert E.	New Albany	Floyd
Laird, L. A.	Richmond	Wayne-Union
Lamb, E. B.	Indianapolis	Marion
Lamb, Russell	Indianapolis	Marion
Lamber, C. K.	Indianapolis	Marion
Lamey, James L.	Anderson	Madison
Lamey, P. T.	Anderson	Madison
Lancet, Robert O.	Terre Haute	Vigo
Land, Richard N.	Houston, Tex.	Wayne-Union
Lane, W .H. (H)	Angola	Steuben
Lane, Wm. H.	South Bend	St. Joseph
Lang, Joseph E.	South Bend	St. Joseph
Lang, Shirley C.	Evansville	Vanderburgh
Langdon, H. K. (H)	Indianapolis	Marion
Langenbahn, C. J.	South Bend	St. Joseph
Langohr, John	Columbia City	Whitley
Langsdon, Fred	Gaston	Delaware-Blackford
Lansford, John	Redkey	Jay
Laramore, Ward	Indianapolis	Marion
Larkin, Bernard J.	Indianapolis	Marion
Larmore, J. L.	Anderson	Madison
Larmore, Sarah H.	Anderson	Madison
LaRocca, Joseph	Valparaiso	Porter
Larrabee, James F.	Hammond	Lake
Larrabee, W. H. (H)	New Palestine	Hancock
Larrison, G. D.	Morocco	Jasper-Newton
Larson, G. O.	La Porte	La Porte
Larson, John A.	Logansport	Cass
LaSalle, R. M.	Wabash	Wabash
Lashley, Donald L.	Tell City	Perry
Laubscher, Clarence	Evansville	Vanderburgh
Laudeman, W. A.	Elwood	Madison
Lauer, D. B.	Dana	Parke-Vermillion
Lava, Irving M.	Michigan City	La Porte
Lavengood, R. W.	Marion	Grant
Lawler, George F.	Indianapolis	Marion
Lawrence, Edwin A.	Indianapolis	Marion
Lawrence, Joseph C.	Evansville	Vanderburgh
Laws, H. J.	Lafayette	Tippecanoe
Laws, Kenneth F.	Lafayette	Tippecanoe
Lawson, I. H.	Kendallville	Noble
Layman, Daniel W. (H)	Indianapolis	Marion
Lazo, Vicente R.	Hammond	Lake

Name	City	County
Leak, Robert H.	Boswell	Benton
Leasure, J. K.	Indianapolis	Marion
Leatherman, H. L.	Indianapolis	Marion
Lebioda, Henry S.	Gary	Lake
Lee, A. H.	Terre Haute	Vigo
Lee, Glen Ward	Richmond	Wayne-Union
Leff, Abe	Indianapolis	Marion
Leffel, James M.	Indianapolis	Marion
Lehman, Harold	Berne	Adams
Lehman, Kenneth M.	Topeka	LaGrange
Lehman, Robert J.	Louisville, Ky.	Marion
Lehmberg, O. F.	Columbia City	Whitley
Lehner, John H.	Fort Wayne	Allen
Leich, Charles F.	Evansville	Vanderburgh
Leninger, Hilbert A. P.	Warsaw	Kosciusko
Leming, Ben L.	Ft. Wayne	Allen
Lemon, Herbert K.	Logansport	Cass
Lemons, James A.	Ft. Wayne	Allen
Lenk, George G.	Fort Wayne	Allen
Leiter, Forrest C.	Marion	Grant
Leonard, Henry S. (H)	Indianapolis	Marion
Leser, R. U.	Indianapolis	Marion
Leslie, Ermil	Evansville	Vanderburgh
Lett, Emory B.	Loogootee	Daviess-Martin
Levi, Leon	Indianapolis	Marion
Levin, Eli	East Chicago	Lake
Levin, Ralph T.	Indianapolis	Marion
Lewis, James F.	Liberty	Wayne-Union
Lewis, Marvin A.	Chicago, Ill.	Lake
Lewis, Robert J.	Lawrence	Marion
Libbert, Edwin L.	Indianapolis	Marion
Lichtenberg, Melvin	Indianapolis	Marion
Lidikay, Edward C.	Indianapolis	Marion
Life, Homer	New Castle	Henry
Lindenborg, Paul G.	Indianapolis	Marion
Lindsay, H. B.	Washington	Daviess-Martin
Line, H. E.	Chili	Miami
Ling, John F.	Richmond	Wayne-Union
Lingeman, Byron N.	Crawfordsville	Montgomery
Lingeman, Raleigh E.	Indianapolis	Marion
Lingeman, Roger	Indianapolis	Marion
Link, Goethe	Indianapolis	Marion
Linn, E. E.	La Porte	La Porte
Linton, C. D.	Walkerton	St. Joseph
Linton, C. E.	Medaryville	Pulaski
Lionberger, John R.	South Bend	St. Joseph
Lippoldt, Charles L.	Batesville	Ripley
Liss, Emanuel C.	South Bend	St. Joseph
List, Harold E.	Glenview, Ill.	Grant
Littell, J. J.	Indianapolis	Marion
Little, John W. (H)	Indianapolis	Marion
Little, Wm. J.	Indianapolis	Marion
Littlefield, Paul A.	Indianapolis	Marion
Litzenberger, S. W.	Anderson	Madison
Lloyd, Claude A.	Washington	Daviess-Martin
Lloyd, John T.	Louisburg, N.C.	Wells
Lloyd, Robert P.	Secone, Pa.	Allen
Lochry, R. L.	Indianapolis	Marion
Lockhart, Jack M.	Connersville	Fayette-Franklin
Lockhart, Philip B.	South Bend	St. Joseph
Loehr, W. M.	Indianapolis	Marion
Loewenstein, W. L.	Terre Haute	Vigo
Logan, A. R. (H)	Petersburg	Pike
Logan, F. W.	Mishawaka	St. Joseph
Logan, James Z.	Richmond	Wayne-Union
Logan, Jesse R.	Evansville	Vanderburgh
Logan, Richard S.	Elkhart	Elkhart
Lohman, Robert M.	Fort Wayne	Allen
Lomax, Claude	Lincoln City	Spencer
Long, Max	Marion	Grant
Long, Paul L.	Anderson	Madison
Loomis, N. S.	Indianapolis	Marion
Loop, Floyd A.	Lafayette	Tippecanoe
Loop, Frederick A.	Lafayette	Tippecanoe
Lord, G. C.	Indianapolis	Marion
Lorenty, T. B.	Gary	Lake
Loring, Mark L.	Valparaiso	Porter
Lorman, James G.	Indianapolis	Marion
Loudermilk, J. L.	Ft. Wayne	Allen
Love, George N.	Indianapolis	Marion
Love, John R.	Terre Haute	Vigo
Lovell, Martin H.	Gary	Lake
Lovett, H. D.	Whitestown	Boone
Loving, J. B.	New Goshen	Vigo
Luckett, Coen L.	Terre Haute	Vigo
Luckey, H. A.	Wolf Lake	Noble
Luckey, R. C.	Wolf Lake	Noble
Ludwick, Harry	South Bend	St. Joseph
Ludwig, Oscar D.	Indianapolis	Marion
Lukemeyer, Geo. T.	Indianapolis	Marion
Lukemeyer, St. John	Jasper	Dubois
Lukemeyer, L. C. (H)	Huntingburg	Dubois
Lukenbill, Emery D.	Indianapolis	Marion
Lundeberg, Ralph A.	Griffith	Lake
Lundt, Milo O.	Elkhart	Elkhart
Lung, B. D.	Kokomo	Howard
Lutes, D. L.	Bloomington	Owen-Monroe
Luthy, Karl R.	South Bend	St. Joseph
Lutz, Georgianna	Gary	Lake
Luzadder, J. E. (H)	Bloomington	Owen-Monroe
Luzadder, J. E., Jr.	New Carlisle	St. Joseph
Lybrook, D. E.	Young America	Cass
Lybrook, William B.	Indianapolis	Marion
Lynch, Harold D.	Evansville	Vanderburgh
Lynch, Otis R.	Marengo	Crawford
Lynch, Paul	Evansville	Vanderburgh
Lynn, F. M. (H)	Peru	Miami
Lyon, Florence	Portland	Jay
Lyons, R. E., Jr.	Bloomington	Owen-Monroe
M		
MacDonald, J. A.	Indianapolis	Marion
MacDonnell, Thomas M.	Indianapolis	Marion
MacKenzie, Pierce	Evansville	Vanderburgh
Macer, Clarence G.	Evansville	Vanderburgh
Machledt, J. H.	Whiteland	Johnson
Mackel, Freederick O.	Ft. Wayne	Allen
Mackey, Harry S.	Indianapolis	Marion
Mackey, John E.	Indianapolis	Marion
Macy, George W.	Columbus	Bartholomew-Brown
Mader, John H.	Richmond	Wayne-Union
Madtson, A. Ricks	Indianapolis	Marion
Magennis, H. L.	Indianapolis	Marion
Mahoney, Charles L.	Terre Haute	Vigo
Mahuron, Boyd L.	Muncie	Delaware-Blackford
Majsterek, S. L.	Gary	Lake
Makovsky, Theodore	Valparaiso	Porter
Malcolm, Russell	Richmond	Wayne-Union
Malmstone, F. A.	Griffith	Lake
Malone, L. A.	Terre Haute	Vigo
Malott, Fred	Converse	Miami
Malouf, S. D.	Peru	Miami
Manalan, Maurice M.	Indianapolis	Marion
Manifold, Harold M.	Fortville	Hancock
Manion, Marlow W.	Indianapolis	Marion
Manley, Chas. N.	Rising Sun	Dearborn-Ohio
Mann, Mortimer	Indianapolis	Marion
Manning, Joseph C.	Indianapolis	Marion
Manning, K. R.	Indianapolis	Marion
Manuel, Donald	Edinburg	Johnson
Manzie, Michael	Lyons	Greene
Maple, J. B.	Sullivan	Sullivan
Marchand, Austin F.	Haubstadt	Gibson
Marchand, Edwin V.	Haubstadt	Gibson

Name	City	County
Marchant, Clarence H.	Bloomington	Owen-Monroe
Marcus, Emanuel	Hammond	Lake
Marcus, M. C.	Gary	Lake
Maris, Lee J.	Attica	Fountain-Warren
Markel, I. J.	Elkhart	Elkhart
Markey, R. J. P.	Hammond	Lake
Markle, Joseph G.	Hammond	Lake
Marks, H. H.	Huntington	Huntington
Marks, Maurice I.	Indianapolis	Marion
Marks, Ora L.	East Chicago	Lake
Marks, Salvo P.	Hammond	Lake
Marr, Griffith	Columbus	Bartholomew-Brown
Marsh, Chester A.	Hagerstown	Henry
Marsh, George W.	Lafayette	Tippecanoe
Marshall, Albert L., Jr.	Indianapolis	Marion
Marshall, C. R.	Indianapolis	Marion
Marshall, George L.	Bourbon	Marshall
Marshall, Lloyd C.	Mt. Summit	Henry
Marshall, Millard R.	Whiting	Lake
Martin, C. E.	Lynn	Randolph
Martin, Charles F.	Mishawaka	St. Joseph
Martin, Floyd S.	Goshen	Elkhart
Martin, Frank D.	Bedford	Lawrence
Martin, Guy	Seymour	Jackson
Martin, Hugh E.	Indianapolis	Marion
Martin, H. G.	Lafayette	Tippecanoe
Martin, Joe M	Lafayette	Tippecanoe
Martin, Loren H.	Indianapolis	Marion
Martin, W. B.	La Porte	La Porte
Martz, Bill L.	Indianapolis	Marion
Martz, Carl D.	Indianapolis	Marion
Marvel, Robert J.	Indianapolis	Marion
Maschmeyer, R. H.	Shoals	Daviess-Martin
Mason, Bernard	South Bend	St. Joseph
Mason, Donald G.	Angola	Steuben
Mason, Everett E.	Evansville	Vanderburgh
Mason, Lester M.	Terre Haute	Vigo
Mason, L. R.	Muncie	Delaware-Blackford
Masters, John B.	San Luis Obispo, Cal.	Marion
Masters, John M.	Indianapolis	Marion
Masters, R. J.	Indianapolis	Marion
Mather, Robert	W. Lafayette	Tippecanoe
Mather, J. W.	East Gary	Lake
Mathews, W. C.	Kentland	Jasper-Newton
Mathys, Alfred	Mauckport	Harrison
Matthew, John R.	North Judson	Starke
Matthew, W. B.	Indianapolis	Marion
Matthews, B. J.	Indianapolis	Marion
Matthews, Chas. B. (H)	Hammond	Lake
Matthews, D. W.	North Vernon	Jennings
Matthews, William M.	Indianapolis	Marion
Mattox, Don M.	Terre Haute	Vigo
Maurer, J. F.	Brazil	Clay
Maurer, Robert M.	Brazil	Clay
Maxon, Roy V.	Lapel	Madison
Maxwell, J. B. (H)	Logansport	Cass
May, George A.	Madison	Jefferson
May, R. Milton.	Gary	Lake
Mayfield, C. H.	Reynolds	White
McAdams, Hugh B.	Lafayette	Tippecanoe
McArdle, Edward G.	Ft. Wayne	Allen
McArt, Bruce A.	Indianapolis	Marion
McBride, James S.	Indianapolis	Marion
McBride, Noel S.	Terre Haute	Vigo
McCabe, J. E. (H)	Otterbein	Benton
McCabe, Theodore E.	Ft. Wayne	Allen
McCallister, John W.	Ft. Wayne	Allen
McCallum, J. T. C.	Indianapolis	Marion
McCarthy, Daniel J. (H)	Indianapolis	Marion
McCarthy, Jeremiah A.	Whiting	Lake
McCartney, Donald H.	Indianapolis	Marion
McCarty, Virgil	Princeton	Gibson
McCaskey, C. H.	Indianapolis	Marion
McCaskey, G. H.	Winamac	Pulaski
McClain Edwin S.	Indianapolis	Marion
McClain, Marvin	Scottsburg	Scott
McClellan, John B.	Muncie	Delaware-Blackford
McClelland, D. C.	Lafayette	Tippecanoe
McClelland, Harry N.	Millersburg	Elkhart
McClintock, James A.	Muncie	Delaware-Blackford
McClure, S. E.	Monon	White
McConnell, Wm. C.	Sunman	Ripley
McCool, J. H.	Evansville	Vanderburgh
McCool, W. E. (H)	Evansville	Venderburgh
McCord, C. B.	Veedersburg	Fountain-Warren
McCormick, C. O., Jr.	Indianapolis	Marion
McCormick, C. O., Sr.	Indianapolis	Marion
McCormick, H. D.	Vincennes	Knox
McCormick, W. C.	Terre Haute	Vigo
McCown, P. E.	Indianapolis	Marion
McCoy, George E.	Muncie	Delaware-Blackford
McCoy, Roy R.	Ft. Wayne	Allen
McCracken, J. O.	Montgomery	Daviess-Martin
McCraley, William J.	South Bend	St. Joseph
McCullough, J. Y.	New Albany	Floyd
McDaniel, F. P.	Atlanta	Hamilton
McDevitt, D. R.	Indianapolis	Marion
McDonald, Frank C.	New Castle	Henry
McDonald, J. D.	University City, Mo.	Vanderburgh
McDonald, R. M.	South Bend	St. Joseph
McDonald, V. G.	Anderson	Madison
McDowell, Fletcher W.	Muncie	Delaware-Blackford
McDowell, George A.	Ft. Wayne	Allen
McDowell, M. M.	Vincennes	Knox
McEachern, Cecil	Ft. Wayne	Allen
McElroy, J. S.	New Castle	Henry
McElroy, R. S.	Princeton	Gibson
McEwen, J. W.	Terre Haute	Vigo
McFadden, James M.	Lafayette	Tippecanoe
McFall, J. R. S.	Ft. Wayne	Allen
McFarland, Corley B.	South Bend	St. Joseph
McGrath, Michael F.	Indianapolis	Marion
McGuff, Paul	Indianapolis	Marion
McGuire, D. F.	East Chicago	Lake
McIlroy, Richard J.	Claypool	Kosciusko
McIlwain, Eleanor	Marion	Grant
McIlwain, Robert	Marion	Grant
McIndoo, R. E.	Kokomo	Howard
McIntire, Clarence R.	Indianapolis	Marion
McIntosh, Wilbert (H)	Riley	Vigo
McIntyre, Charles J.	Indianapolis	Marion
McIntyre, J. M.	Indianapolis	Marion
McKay, Robert	Indianapolis	Marion
McKechnie, Franklin B.	Indianapolis	Marion
McKee, C. E. (H)	Dublin	Wayne-Union
McKee, Horace N. (H)	Elkhart	Elkhart
McKee, H. S.	Greensburg	Decatur
McKeeman, D. H.	Ft. Wayne	Allen
McKeeman, L. S.	Ft. Wayne	Allen
McKenna, H. J.	South Bend	St. Joseph
McKinley, A. D.	Indianapolis	Marion
McKinney, D. H.	Lafayette	Tippecanoe
McKittrick, Jack	Washington	Daviess-Martin
McLaughlin, C. P.	Pendleton	Madison
McLaughlin, G. C.	Terre Haute	Vigo
McLaughlin, James R.	Flora	Carroll
McLean, James S.	Hammond	Lake
McLelland, Mary R.	Indianapolis	Marion
McMahan, Virgil	Vincennes	Knox
McMeel, J. E.	South Bend	St. Joseph

Name	City	County
McMichael, F. J.	Gary	Lake
McMichael, R. M.	Muncie	Delaware-Blackford
McMillan, F. G.	Indianapolis	Marion
McNabb, G. B.	Carthage	Rush
McNairy, Donald J.	Ft. Wayne	Allen
McNamara, John P.	Indianapolis	Marion
McNaughton, L. M.	Washington	Daviess-Martin
McNeely, M. J.	Dillsboro	Dearborn-Ohio
McQuiston, R. J.	Indianapolis	Marion
McTurnan, Robert W.	Indianapolis	Marion
McVaugh, Charles C.	Chicago, Ill.	Madison
McVey, Clarence A.	Hammond	Lake
McWilliams, W. B.	Liberty	Wayne-Union
Mead, C. H.	Bluffton	Wells
Meade, Walter W.	Bicknell	Knox
Medcalf, Norman L.	Lamar	Spencer
Megenhardt, D. S.	Indianapolis	Marion
Mehl, Rudolph A.	Evansville	Vanderburgh
Meihaus, John E.	Los Angeles, Calif.	Marion
Meikle, Louise J.	W. Lafayette	Tippecanoe
Meiks, Lyman T.	Indianapolis	Marion
Meiner, J. A.	Kokomo	Howard
Meiser, Robert	Huntington	Huntington
Meister, Doris	Anderson	Madison
Melloh, A. F.	Indianapolis	Marion
Mendenhall, Clarence D.	Indianapolis	Marion
Mendenhall, Edgar	Ft. Wayne	Allen
Mendez, Carlos	Elkhart	Elkhart
Mentendiek, M. H.	Indianapolis	Marion
Mercer, Samuel R.	Ft. Wayne	Allen
Merchant, Raymond	Crown Point	Lake
Meredith. E. J.	Richmond	Wayne-Union
Mericle, Earl W.	Indianapolis	Marion
Merrell, B. M.	Rockville	Parke-Vermillion
Merrell. Paul	Indianapolis	Marion
Mertz, H. O.	Indianapolis	Marion
Mervis, Frank H.	East Chicago	Lake
Messer, F. W.	Kendallville	Noble
Metcalf, George B.	Anderson	Madison
Metcalfe, G. E.	South Bend	St. Joseph
Mettler, Don C.	Denver, Colo.	De Kalb
Meyer, Herman A.	Ft. Wayne	Allen
Meyer, K. T.	Evansville	Vanderburgh
Meyer, Milo G.	Michigan City	La Porte
Meyer, Orlando L.	Bedford	Lawrence
Meyer, R. C.	Vincennes	Knox
Meyer, Theodore O.	Ft. Wayne	Allen
Meyn, Werner P.	Terre Haute	Vigo
Michael, Amos C.	Indianapolis	Marion
Michael, Isaac E.	Rochester, Minn.	Clinton
Michaelis, S. C.	Ft. Wayne	Allen
Micheli, A. J.	Indianapolis	Marion
Middleton, H. N.	Indianapolis	Marion
Middleton, Thomas O.	Bloomington	Owen-Monroe
Mikesch, W. H.	South Bend	St. Joseph
Miklozek, John E.	Terre Haute	Vigo
Miley, Weir M.	Anderson	Madison
Miller, Carl G.	Ft. Wayne	Allen
Miller, Charles A. (H)	Princeton	Gibson
Miller, D. B.	Terre Haute	Vigo
Miller, E. H.	Valparaiso	Porter
Miller, Frank	Morristown	Shelby
Miller, H. Allison	Marion	Grant
Miller, H. L.	West Baden	Orange
Miller, Harold E.	Seymour	Jackson
Miller, H. Paul	Ft. Wayne	Allen
Miller, Hugh A.	Elkhart	Elkhart
Miller, Iva M.	Indianapolis	Marion
Miller, J. Don	Indianapolis	Marion
Miller, James C.	Greensburg	Decatur
Miller, John R.	Indianapolis	Marion
Miller, LaVerne B.	Evansville	Vanderburgh
Miller, M. E.	Goshen	Elkhart
Miller, Mahlon F.	Ft. Wayne	Allen
Miller, Mary E.	Bloomington	Owen-Monroe
Miller, Milton	Evansville	Vanderburgh
Miller, Milo	South Bend	St. Joseph
Miller, Minor	Evansville	Vanderburgh
Miller, Orval J.	Ft. Wayne	Allen
Miller, R. S.	Indianapolis	Marion
Miller, Ray D.	Martinsville	Morgan
Miller, Richard C.	Shelbyville	Shelby
Miller, Richard H.	Ft. Wayne	Allen
Miller, Robert J.	Evansville	Vanderburgh
Miller, Roland E.	Lafayette	Tippecanoe
Miller, S. J.	W. Lafayette	Tippecanoe
Miller, S. T.	Elkhart	Elkhart
Miller, Virgil	Akron	Fulton
Miller, Wallace	Indianapolis	Marion
Miller, Wm. A.	Hagerstown	Henry
Miller, Wm. E.	South Bend	St. Joseph
Miller, Wm. J.	Ft. Wayne	Allen
Millikan, William	Indianapolis	Marion
Mills, Fred E.	Evansville	Vanderburgh
Mills, J. F.	Wabash	Wabash
Minczewski, Richard C.	Gary	Lake
Mininger, Edward P.	Elkhart	Elkhart
Mino, Raymond W.	Evansville	Vanderburgh
Mino, Victor H.	Evansville	Vanderburgh
Mirro, John A.	Lowell	Lake
Mishkin, Irving	Elkhart	Elkhart
Mitchell, Albert M.	Terre Haute	Vigo
Mitchell, E. T.	Romney	Tippecanoe
Mitchell, Earl H.	Indianapolis	Marion
Mitchell, G. L.	Smithville	Owen-Monroe
Mitchell, George S.	Bluffton	Wells
Mitchell, R. E.	Springfield, Missouri	Marion
Mitman, F. B.	Huntington	Huntington
Moats, C. F.	Ft. Wayne	Allen
Moats, G. E.	Ft. Wayne	Allen
Modisett, Jackson W.	Madison	Jefferson
Modisett, Marcella S.	Madison	Jefferson
Modjeski, Joseph R.	Hammond	Lake
Modjeski, Raymond J.	Hammond	Lake
Moehlenkamp, C. E.	Evansville	Vanderburgh
Moenning, W. P.	Indianapolis	Marion
Mohr, Ann L. M.	West Terre Haute	Vigo
Molenda, Robert V.	Michigan City	LaPorte
Molengraft, C. J.	Gary	Lake
Molloy, W. J. (H)	Muncie	Delaware-Blackford
Molt, W. F.	Indianapolis	Marion
Monroe, F. Bruce	Crown Point	Lake
Montgomery, J. R.	Owensville	Gibson
Montgomery, L. G.	Muncie	Delaware-Blackford
Montgomery, S. B. (H)	Cynthiana	Posey
Montgomery, Wm. F.	Indianapolis	Marion
Moore, B. B.	Indianapolis	Marion
Moore, Edwin G.	Gary	Lake
Moore, E. Gregory	Gary	Lake
Moore, H. T.	Indianapolis	Marion
Moore, R. G.	Vincennes	Knox
Moore, Robert M.	Indianapolis	Marion
Moore, Thomas C.	Indianapolis	Delaware-Blackford
Moore, W. C.	Muncie	Delaware-Blackford
Moosey, Louis	Union Mills	LaPorte
Moran, Mark M.	Portland	Jay
Moran, Noel D.	Versailles	Ripley
Moravec, Arthur E.	Ft. Wayne	Allen
Morchan, Samuel	Indianapolis	Marion
Morec, George J.	Indianapolis	Marion
Morford, Guy	Kokomo	Howard
Morgan, Margaret E.	Indianapolis	Marion

Name	City	County
Morgan, S. P.	LaPorte	LaPorte
Moriarty, John R.	Indianapolis	Marion
Morr, J. W. (H)	Albion	Noble
Morrical, Russell J.	Logansport	Cass
Morris, Hyman	Gary	Lake
Morris, J. W.	Muncie	Delaware-Blackford
Morris, Warren V.	Monticello	White
Morris, W. F. (H)	Princeton	Gibson
Morrison, G. G.	Portland	Jay
Morrison, John S. (H)	Lafayette	Tippecanoe
Morrison, J. T.	Greensburg	Decatur
Morrison, Lindsey (H)	Hammond	Lake
Morrison, Lewis E. II	Indianapolis	Marion
Morrison, W. R.	Kokomo	Howard
Morrow, George W.	Logansport	Cass
Mortenson, L. J.	Ft. Wayne	Allen
Morton, Walter P.	Indianapolis	Marion
Moser, E. B.	Windfall	Tipton
Moser, Edward (H)	Woodburn	Allen
Moser, R. H.	Indianapolis	Marion
Moses, George E.	Worthington	Greene
Moses, Robert E.	Worthington	Greene
Moss, Harlan B.	Indianapolis	Marion
Moss, M. J.	Yorktown	Delaware-Blackford
Moswin, Jack A.	Gary	Lake
Mothersill, M. H.	Indianapolis	Marion
Mott, C. A.	South Bend	St. Joseph
Moulton, Lillian	Indianapolis	Marion
Mount, M. S.	Bloomfield	Greene
Mount, Wm. M.	Crawfordsville	Montgomery
Mountain, Francis	Connersville	Fayette-Franklin
Mozingo, A. E.	Indianapolis	Marion
Muelchi, Adeline F.	Evansville	Vanderburgh
Mueller, Hilbert M.	South Bend	St. Joseph
Mueller, Lawrence W.	Ft. Wayne	Allen
Mueller, Lillian B.	Indianapolis	Marion
Muhleman, C. E.	LaPorte	LaPorte
Mull, P. L. (H)	Louisville, Ky.	Washington
Muller, Lullus P.	Indianapolis	Marion
Muller, Paul F.	Indianapolis	Marion
Mullikin, C. W.	Greensburg	Decatur
Mumford, E. B.	Indianapolis	Marion
Munk, C. E.	Kendallville	Noble
Murdock, H. L.	Ft. Wayne	Allen
Murphy, E. C.	South Bend	St. Joseph
Murphy, E. W.	New Albany	Floyd
Murphy, Edward U.	Evansville	Vanderburgh
Murphy, George M.	Franklin	Johnson
Murphy, Harry	Franklin	Johnson
Murphy, Joseph F., Jr.	Hammond	Lake
Murphy, Josephine	South Bend	St. Joseph
Murphy, M. G.	Morgantown	Morgan
Murray, Ernest C.	Kokomo	Howard
Murray, Jas. S., Jr.	Beverly Hills, Calif.	Marion
Musacchio, Frederick A.	Hammond	Lake
Musselman, G. G.	Terre Haute	Vigo
Myers, Charles W.	Indianapolis	Marion
Myers, Paul W.	Indianapolis	Marion
Myers, R. V.	Indianapolis	Marion
Myers, Wm. C.	Dana	Parke-Vermillion
N		
Nafe, C. A.	Indianapolis	Marion
Nagan, Robert F.	Indianapolis	Marion
Nahrwold, Elmer W.	Ft. Wayne	Allen
Nakadate, Katsumi J.	East Chicago	Lake
Nance, W. K.	Vincennes	Knox
Napper, Floyd	Scottsburg	Scott
Nash, Charles B.	Valparaiso	Porter
Nash, Justin R.	Albion	Noble
Nason, R. A.	Garrett	DeKalb
Nassef, George	Walkerton	St. Joseph
Naugle, R. A.	Wabash	Wabash
Nave, H. E.	Fountaintown	Shelby
Navin, Hugh K.	Fortville	Hancock
Nay, E. O.	Terre Haute	Vigo
Nay, Richard M.	Indianapolis	Marion
Neal, Leonard W.	Hammond	Marion
Neale, Alfred E.	Anderson	Madison
Need, Louis T.	Indianapolis	Marion
Neely, A. S.	Indianapolis	Marion
Nehil, L. W.	Indianapolis	Marion
Neidballa, E. G.	Bristol	Elkhart
Neier, O. C. (H)	Indianapolis	Marion
Neifert, Noel	Tell City	Perry
Nelson, Carl A.	West Lebanon	Fountain-Warren
Nelson, F. Dale	South Bend	St. Joseph
Nelson, Paul Leon	Anderson	Madison
Nelson, R. B.	Hammond	Lake
Nelson, Raymond	South Bend	St. Joseph
Nelson, Walfred A.	Gary	Lake
Nenneker, Henry (H)	Evansville	Vanderburgh
Nesbit, L. L.	Anderson	Madison
Nesbit, O. B. (H)	Gary	Lake
Nester, Henry G.	Indianapolis	Marion
Netherton, C. R.	Chalmers	White
Neucks, Howard C.	Evansville	Vanderburgh
Neudorff, Louis G.	Terre Haute	Vigo
Neukamp, Frank H.	Connersville	Fayette-Franklin
Neumann, K. O.	Lafayette	Tippecanoe
Neuwalt, Frank	Gary	Lake
Newby, A. C.	Sheridan	Hamilton
Newby, Eugene	Sheridan	Hamilton
Newcomb, Wm. K.	Royal Center	Cass
Newland, A. E.	Bedford	Lawrence
Newman, A. E.	Evansville	Vanderburgh
Niblack, J. S.	East Chicago	Lake
Nichols, Anne Sackett	Greencastle	Putnam
Nichols, Wm. E. (H)	Hammond	Lake
Nickel, Allen C.	Bluffton	Wells
Nicosia, J. B.	East Chicago	Lake
Nie, Grover	Huntington	Huntington
Nie, Louis W.	Indianapolis	Marion
Niedermayer, Alfred	Evansville	Vanderburgh
Nigh, R. M.	Fairland	Shelby
Nill, John H.	Ft. Wayne	Allen
Nisenbaum, Harold	Evansville	Vanderburgh
Nixon, Byron	Farmland	Randolph
Noble, T. B., Jr.	Indianapolis	Marion
Nodinger, Louis	Hammond	Lake
Nodurft, Joseph H.	Indianapolis	Marion
Noe, Wm. R.	Indianapolis	Marion
Nolan, Robert E.	English	Crawford
Nolt, E. V.	Columbia City	Whitley
Nolting, H. F.	Indianapolis	Marion
Nonte, Leo R.	Evansville	Vanderburgh
Norman, Wm. H.	Indianapolis	Marion
Norman, O. B.	Indianapolis	Marion
Norris, Allen A. (H)	Elkhart	Elkhart
Norris, Ernest B.	Middlebury	Elkhart
Norris, H. L.	Indianapolis	Marion
Norris, Mary A.	Rio de Janiero, Brazil	Marion
Norris, Max S.	Indianapolis	Marion
Norton, H. J.	Columbus	Bartholomew-Brown
Norton, Horace	Washington	Daviess-Martin
Norwick, Sydney	San Lorenzo, Calif.	Marion
Nourse, Myron H.	Indianapolis	Marion
Nugen, Harold	Auburn	DeKalb
Nugent, Edwin J.	Indianapolis	Marion
Nutter, Wyndham H.	Rushville	Rush
O		
Oak, David	Hanna	LaPorte
Oak, D. D.	La Crosse	LaPorte

Name	City	County
Obery, George	Batesville	Ripley
O'Bryan, Richard B.	Columbus	Bartholomew-Brown
Ochsner, Harold C.	Indianapolis	Marion
Ockerman, Kenneth R.	Demotte	Jasper-Newton
O'Conner, James J.	East Chicago	Lake
O'Dell, Harry C.	Farmersburg	Sullivan
O'Dell, Thomas A.	Indianapolis	Marion
Olcott, C. W.	Aurora	Dearborn-Ohio
O'Leary, F. T.	Logansport	Cass
Oliphant, F. W.	Mount Vernon	Posey
Oliphant, J. T.	Farmersburg	Sullivan
Oliphant, R. W.	Terre Haute	Vigo
Olney, Thomas A. (H)	South Bend	St. Joseph
Olson, K. L.	South Bend	St. Joseph
Olvey, Ottis N.	Indianapolis	Marion
O'Malley, Martha	Indianapolis	Marion
Omstead, Milton	Petersburg	Pike
Omstead, Trevalyn W.	Huntington	Huntington
O'Neil, Martin J.	Rensselaer	Jasper-Newton
Openshaw, J. F.	Goodland	Jasper-Newton
Oppenheimer, Ernst	Evansville	Vanderburgh
Orders, C. E.	Indianapolis	Marion
Ornelas, Joseph P.	Gary	Lake
O'Rourke, Carroll	Ft. Wayne	Allen
Orr, Wm. Robert	Mishawaka	St. Joseph
Osborne, Harry S.	Roachdale	Putnam
Osterman, Louis	Seymour	Jackson
Oswald, Robert H.	Evansville	Vanderburgh
Oswalt, James T.	Mitchell	Lawrence
Otten, Claude F.	Indianapolis	Marion
Otten, Ralph E.	Darlington	Montgomery
Ottinger, R. C.	Indianapolis	Marion
Overman, F. V.	Tipton	Tipton
Overpeck, Charles	Greensburg	Decatur
Overpeck, George H.	Alexandria	Madison
Overshiner, Lyman	Columbus	Bartholomew-Brown
Owen, Abraham	Bloomington	Owen-Monroe
Owen, J. E.	Indianapolis	Marion
Owen, Margaret A.	Bloomington	Owen-Monroe
Owens, Richard R.	Muncie	Delaware-Blackford
Owens, Thomas R.	Muncie	Delaware-Blackford
Owens, Tracy	Indianapolis	Marion
Owens, Walter Lee	Bloomington	Owen-Monroe
Owsley, Charlotte M.	Hartford City	Delaware-Blackford
Owsley, Guy A.	Hartford City	Delaware-Blackford
Oyer, J. H.	Ft. Wayne	Allen

P

Pace, J. V.	New Albany	Floyd
Paff, W. A.	Elkhart	Elkhart
Pahmeier, J. W.	Sandborn	Knox
Paine, George E.	Elkhart	Elkhart
Painter, Donald S.	Ft. Wayne	Allen
Painter, L. W.	Winchester	Randolph
Palm, John M.	Brazil	Clay
Palmer, Russell H.	Gary	Lake
Panares, Solomon V.	Hammond	Lake
Pancost, Ruth Hoetzer	Elkhart	Elkhart
Pancost, Vernon K.	Elkhart	Elkhart
Pandolfo, Harry	Indianapolis	Marion
Paris, D. W.	Kokomo	Howard
Paris, J. M.	New Albany	Floyd
Parke, D. Davis	South Bend	St. Joseph
Park, Byron J.	Indianapolis	Marion
Parker, Carl B.	Wingate	Montgomery
Parker, C. B.	Ft. Wayne	Allen
Parker, E. E. (H)	Oxford	Benton
Parker, G. F.	Greencastle	Putnam
Parker, Geo. F., Jr.	Indianapolis	Marion
Parker, H. C.	Gary	Lake
Parker, J. F.	Indianapolis	Marion
Parker, Portia	Indianapolis	Marion
Parks, George A.	Hartford City	Delaware-Blackford
Parratt, Louis W.	Gary	Lake
Parrish, Richard K.	Decatur	Adams
Pastor, Julius W.	Evansville	Vanderburgh
Patrick, G. B.	Elkhart	Elkhart
Patten, V. C. (H)	Morristown	Shelby
Patterson, Cecil L.	Charlestown	Clark
Patterson, Wm. K.	Anderson	Madison
Patton, Martin T.	Indianapolis	Marion
Paul, Wm. Thomas F.	Hammond	Lake
Paulissen, George T.	Indianapolis	Marion
Pauszek, Thomas B.	South Bend	St. Joseph
Payne, Arthur C.	East Chicago	Lake
Paynter, Morris B.	Southport	Marion
Peacock, Norman F.	Crawfordsville	Montgomery
Peacock, Robert	Muncie	Delaware-Blackford
Pearce, Roy V.	Terre Haute	Vigo
Pearlman, Samuel	Lafayette	Tippecanoe
Pearson, John R. (H)	Bedford	Lawrence
Pearson, Lyman R.	Indianapolis	Marion
Pearson, William E.	Wabash	Wabash
Pebworth, A. C.	Indianapolis	Marion
Peck, Franklin B.	Indianapolis	Marion
Peck, Edward A.	Hammond	Lake
Peck, James F.	Princeton	Gibson
Pectol, Charles F.	Spencer	Owen-Monroe
Peiffer, Geraldine M.	Hammond	Lake
Peirce, James D.	Indianapolis	Marion
Pence, Benjamin F.	Columbia City	Whitley
Pennington, W. E.	Indianapolis	Marion
Pentecost, Paul S.	New Orleans, La.	Wayne-Union
Permer, Erwin	Indianapolis	Marion
Perrin, K. F.	Ft. Wayne	Allen
Perry, F. G.	Ft. Wayne	Allen
Peters, Elmer E.	Brookville	Fayette-Franklin
Peters, R. J. D.	Indianapolis	Marion
Peterson, Joel A.	Lafayette	Tippecanoe
Petitjean, H. G.	Haubstadt	Gibson
Petranoff, T. V.	Indianapolis	Marion
Petrass, Andrew	South Bend	St. Joseph
Petronella, S. J.	East Chicago	Lake
Pettijohn, F. L. (H)	Indianapolis	Marion
Petway, Allen P.	Madison	Jefferson
Peyton, Frank W.	Lafayette	Tippecanoe
Pfaff, Dudley	Indianapolis	Marion
Pfaff, John A. (H)	Indianapolis	Marion
Pfafflin, C. A. (H)	Indianapolis	Marion
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio
Pfuetze, Max	Logansport	Cass
Phares, Robert W.	Kokomo	Howard
Phipps, Elwood B.	Indianapolis	Marion
Phillips, John F.	Ft. Wayne	Allen
Phipps, Leland K.	Union City	Randolph
Piazza, Leonard F.	Michigan City	LaPorte
Pickett, Robert D.	Indianapolis	Marion
Pierce, Gene Stratton	New Albany	Floyd
Pierce, H. J.	Terre Haute	Vigo
Pierce, Wm. J.	Westville, Ill.	Marion
Pierson, P. R.	New Albany	Floyd
Pierson, Robert H.	Crawfordsville	Montgomery
Pierson, Thomas A.	New Palestine	Hancock
Pike, Warren H.	Hobart	Lake
Pilcher, Jack	Indianapolis	Marion
Pilecki, Peter J.	Michigan City	LaPorte

Name	City	County
Pilot, Jean	Hammond	Lake
Pippenger, W. G.	Brook	Jasper-Newton
Pirkle, H. B.	Rockville	Parke-Vermillion
Pitkin, Edward M.	Martinsville	Morgan
Pitkin, M. C.	Martinsville	Morgan
Plain, George	South Bend	St. Joseph
Plank, C. Robert	Michigan City	LaPorte
Ploughe, Monroe L. (H)	Elwood	Madison
Ploughe, R. R.	Elwood	Madison
Polhemus, Gretchen I.	New Albany	Floyd
Polhemus, Warren C.	Anderson	Madison
Pollak, Lewis	Indianapolis	Marion
Pollard, Walter	Evansville	Vanderburgh
Pollom, Robert	Crawfordsville	Montgomery
Pomeroy, Rex K.	Plymouth	Marshall
Pontius, Edwin E.	Camp Atterbury	Marion
Poolitson, Geo. C.	Bloomington	Owen-Monroe
Popp, M. F.	Ft. Wayne	Allen
Popplewell, Arvine G.	Indianapolis	Marion
Porro, Francis W.	Evansville	Vanderburgh
Porter, Carl M.	Jasonville	Greene
Porter, E. A.	Westport	Decatur
Porter, George C.	Linton	Greene
Porter, Jack	Lebanon	Boone
Porter, John R.	Lebanon	Boone
Porter, M. F.	Ft. Wayne	Allen
Portteus, Walter L.	Franklin	Johnson
Possolt, T. R.	Elkhart	Elhart
Poston, C. L.	New Castle	Henry
Potter, Richard M.	Ridgeville	Randolph
Powell, J. Paxton	Marion	Grant
Powell, Nettie B. (H)	Marion	Grant
Premuda, F. E.	Hammond	Lake
Prenatt, Francis	Madison	Jefferson
Prentiss, Nelson M.	Ft. Wayne	Allen
Present, Julian	Evansville	Vanderburgh
Price, Douglas W.	Nappanee	Elkhart
Price, Ernest H.	Danville	Hendricks
Price, James O.	Indianapolis	Marion
Price, Melvin D. (H)	Nappanee	Elkhart
Price, Shirley G.	Evansville	Vanderburgh
Priebe, Fred H.	Hillsboro	Fountain-Warren
Prosser, Wm. O. H.	Bloomington	Owen-Monroe
Proudfit, Charles H.	South Bend	St. Joseph
Province, O. A.	Franklin	Johnson
Province, William D.	Franklin	Johnson
Pryor, R. C.	Indianapolis	Marion
Przednowek, A. C.	LaPorte	LaPorte
Pugh, Willis L.	Evansville	Vanderburgh
Pulskamp, B. H.	Wolcottville	Noble
Purcell, Jack H.	Boonville	Warrick
Purcell, Richard J.	Gary	Lake
Puryear, James O.	Gary	Lake
Puterbaugh, K. E.	Albany	Delaware-Blackford
Pyle, Harold D.	South Bend	St. Joseph
Q		
Quick, Wm. J.	Muncie	Delaware-Blackford
Quickel, Daniel S. (H)	Anderson	Madison
Quigley, Joseph B.	Indianapolis	Marion
R		
Rabb, Frank M.	Indianapolis	Marion
Rabb, Harry	Indianapolis	Marion
Raber, Robert M.	Indianapolis	Marion
Rabson, S. Milton	Ft. Wayne	Allen
Radding, Robert S.	Long Meadow, Mass.	Marion
Rader, George S.	Indianapolis	Marion
Radigan, Leo R.	Indianapolis	Marion
Ragsdale, H. C.	Bedford	Lawrence
Rainey, E. A.	Lebanon	Boone
Ramage, W. F.	Beech Grove	Marion
Ramey, John W.	Kokomo	Howard
Ramker, Daniel T.	East Chicago	Lake
Ramsey, Frank B.	Indianapolis	Marion
Ramsey, H. S.	Bloomington	Owen-Monroe
Ranes, J. R.	Mt. Vernon	Posey
Raney, B. B.	Linton	Greene
Rang, A. A.	Washington	Daviess-Martin
Rang, Robert H.	Washington	Daviess-Martin
Ranke, John W. H. (H)	Ft. Wayne	Allen
Raper, George T.	Freelandville	Knox
Raphael, Isidor J.	Evansville	Vanderburgh
Rariden, L. B.	Greenfield	Hancock
Rasmussen, Ruth F.	South Bend	St. Joseph
Ratcliff, Frank W.	Lafayette	Tippecanoe
Ratcliffe, A. W.	Evansville	Vanderburgh
Rausch, Norman W.	Angola	Steuben
Ravdin, Bernard	Evansville	Vanderburgh
Rawdon, Robert E.	Indianapolis	Marion
Rawles, Lyman T.	Ft. Wayne	Allen
Rawlins, Carolyn M.	Hammond	Lake
Ray, Herbert A.	Ft. Wayne	Allen
Rayl, C. C.	Decatur	Adams
Reck, J. L.	Sheridan	Hamilton
Records, A. W.	Franklin	Johnson
Reed, Ann	Michigan City	LaPorte
Reed, J. V.	Indianapolis	Marion
Reed, John J.	Hobart	Lake
Reed, Nelle C.	Michigan City	LaPorte
Reed, Philip B.	Indianapolis	Marion
Reed, Robert C.	Terre Haute	Vigo
Reed, R. R.	Anderson	Madison
Reed, Wm. C.	Bloomington	Owen-Monroe
Reeder, Henry H.	Jeffersonville	Clark
Rees, Russell C.	Indianapolis	Marion
Regan, George L.	Sellersburg	Clark
Reich, Clarence E.	Evansville	Vanderburgh
Reid, Chas. A.	Indianapolis	Marion
Reid, Robert W.	Union City	Randolph
Reilly, James F.	Vincennes	Knox
Reisler, Simon	Indianapolis	Marion
Reitz, Thomas F.	Evansville	Vanderburgh
Remich, A. C.	Hammond	Lake
Renbarger, L. L.	Marion	Grant
Rendel, D. T.	Hammond	Lake
Rendel, H. E.	Mexico	Miami
Reppert, Roland L.	Decatur	Adams
Rettig, A. C.	Muncie	Delaware-Blackford
Reusser, Amos (H)	Berne	Adams
Reynolds, D. M.	Garrett	DeKalb
Reynolds, J. S.	Gary	Lake
Reynolds, R. P.	Garrett	DeKalb
Reynolds, Richard J.	Terre Haute	Vigo
Rhamy, A. P.	Wabash	Wabash
Rhea, G. D.	Greencastle	Putnam
Rhea, James C.	Beech Grove	Marion
Rhind, A. W.	Hammond	Lake
Rhodes, A. H.	Princeton	Gibson
Rhodes, Theodore D.	Indianapolis	Marion
Rhorer, H. M.	Kokomo	Howard
Rhorer, John G.	Marion	Grant
Rice, Raymond M.	Indianapolis	Marion
Rice, Thurman B.	Indianapolis	Marion
Rice, T. R. (H)	Petersburg	Pike
Rice, W. B.	Ft. Wayne	Allen
Richard, Norman F.	Shelbyville	Shelby
Richards, D. H. (H)	Vincennes	Knox
Richards, E. E.	Russellville	Putnam
Richardson, C. L.	Rochester	Fulton
Richardson, Thad T.	Indianapolis	Marion

Name	City	County
Richart, J. V.	Terre Haute	Vigo
Richer, O. H.	Warsaw	Kosciusko
Richter, Arthur B.	Indianapolis	Marion
Richter, John C.	LaPorte	LaPorte
Richter, Samuel	New Orleans, La.	Lake
Ricketts, J. W.	Indianapolis	Marion
Ridgeway, O. W.	Indianapolis	Marion
Ridgway, Alton H.	Belgian Congo, Africa	Marion
Rifner, E. S.	Van Buren	Grant
Rigg, J. F.	Indianapolis	Marion
Riggs, Floyd	Terre Haute	Vigo
Rigley, E. L.	South Bend	St. Joseph
Riley, Frank (H)	Jamestown	Boone
Rininger, Harold C.	Evansville	Vanderburgh
Rinker, Earl B.	Indianapolis	Marion
Rinne, John I.	Lapel	Madison
Ripley, John W.	Seymour	Jackson
Rissing, Walter J.	Ft. Wayne	Allen
Ritchey, J. O.	Indianapolis	Marion
Ritchie, William D.	Evansville	Vanderburgh
Ritteman, George W.	Columbus	Bartholomew-Brown
Ritter, Wayne L.	Indianapolis	Marion
Ritz, Albert S.	Evansville	Vanderburgh
Rivers, Glynn A.	Muncie	Delaware-Blackford
Robb, John A.	Indianapolis	Marion
Robertson, A. N.	New Albany	Floyd
Robertson, D. W. (H)	Deputy	Jefferson
Robertson, James S.	Plymouth	Marshall
Robertson, M. O.	Bedford	Lawrence
Robertson, Ray	Indianapolis	Marion
Robertson, W. C.	Shipshewana	LaGrange
Robertson, William S.	Spiceland	Henry
Robinson, Earl U.	Evansville	Vanderburgh
Robinson, Walter K.	Gary	Lake
Robison, C. A.	Frankfort	Clinton
Robison, J. S.	Winchester	Randolph
Robrock, Lawrence M.	Michigan City	LaPorte
Rockey, Noah A.	Ft. Wayne	Allen
Rodenbeck, Frank	Arcadia	Hamilton
Rodin, Herman H.	South Bend	St. Joseph
Rodriguez, Juan	Ft. Wayne	Allen
Roesch, Ryland	Indianapolis	Marion
Rogers, Donald L.	Indianapolis	Marion
Rogers, Evered E.	Auburn	DeKalb
Rogers, O. F.	Bloomington	Owen-Monroe
Rogers, R. C. (H)	Bloomington	Owen-Monroe
Rogers, Thomas P.	Philadelphia, Pa.	Marion
Rohn, Robert J.	Indianapolis	Marion
Rohr, Joseph H.	Elkhart	Elkhart
Rohrer, J. R.	Elnora	Daviess-Martin
Roller, C. W.	Indianapolis	Marion
Romberger, Floyd T.	W. Lafayette	Tippecanoe
Romberger, Floyd T., Jr.	Indianapolis	Marion
Rommel, Clarence H.	W. Lafayette	Tippecanoe
Ropp, Eldon R.	Oakland City	Gibson
Ropp, H. E.	New Harmony	Posey
Rose, Stuart	Montreal, Canada	Delaware-Blackford
Rosenak, Bernard D.	Indianapolis	Marion
Rosenbaum, David	Indianapolis	Marion
Rosenbaum, Irving, Jr.	Indianapolis	Marion
Rosenbaum, L. E.	Anderson	Madison
Rosenblatt, B. B.	Evansville	Vanderburgh
Rosenbloom, P. J.	Gary	Lake
Rosenfeld, Norman B.	Clinton	Parke-Vermillion
Rosenheimer, Geo. M.	South Bend	St. Joseph
Rosenwasser, Jacob	Mishawaka	St. Joseph
Roser, A. J.	Ft. Wayne	Allen
Rosevear, Henry J.	Hammond	Lake
Ross, Alexander T.	Indianapolis	Marion
Ross, Ben R.	Bloomington	Owen-Monroe
Ross, Guy E.	Anderson	Madison
Ross, Harry P.	Richmond	Wayne-Union
Ross, James S.	Richmond	Wayne-Union
Ross, Louis F.	Richmond	Wayne-Union
Ross, W. W.	La Porte	La Porte
Rossiter, D. L.	Ft. Wayne	Allen
Rossow, Russell J.	Evansville	Vanderburgh
Roth, Bertram	Indianapolis	Marion
Roth, James	Wolf Lake	Noble
Rothberg, Maurice J.	Ft. Wayne	Allen
Rothenberger, Daniel J.	Roswell, N.M.	Marion
Rothring, Howard E.	Indianapolis	Marion
Rothrock, Philip W.	Lafayette	Tippecanoe
Rothschild, C. J.	Ft. Wayne	Allen
Rotman, Harry G.	Jasonville	Greene
Rotman, Sam I.	Jasonville	Greene
Row, D. Hamilton	Indianapolis	Marion
Row, George S.	Osgood	Ripley
Row, Perrie Q.	Hammond	Lake
Rowdabaugh, Marshall J.	Hines, Ill.	St. Joseph
Rowe, Howard H.	Rochester	Fulton
Royster, Robert A.	Evansville	Vanderburgh
Rozelle ,Clarence V.	Anderson	Madison
Rubens, Eli	South Bend	St. Joseph
Rubin, Gerald S.	Indianapolis	Marion
Rubin, M. R.	Fresno, Calif.	Lake
Rubin, Milton M.	Terre Haute	Vigo
Rubin, Simon S.	Gary	Lake
Ruby, Fred McKemy	Union City	Randolph
Ruch, Jake D.	Indianapolis	Marion
Ruddell, Karl R.	Indianapolis	Marion
Ruddell, Keith R.	Indianapolis	Marion
Ruddick, H. C.	Evansville	Vanderburgh
Rudesill, C. L.	Indianapolis	Marion
Rudesill, Robert	Rochester, Minn.	Marion
Rudicel, Max	Kokomo	Howard
Rudolph, Carl J.	South Bend	St. Joseph
Rudolph, F. G.	Hammond	Lake
Rudolph, Stephen, Jr.	Indianapolis	Marion
Rudser, D. H.	Whiting	Lake
Runge, Paul W.	Richmond	Wayne-Union
Rupe, Lloyd O.	Elkhart	Elkhart
Rupel, Ernest	Indianapolis	Marion
Rusche, Henry J.	Evansville	Vanderburgh
Ruschli, E. B.	Lafayette	Tippecanoe
Rusk, Hubert M.	Wallace	Fountain-Warren
Russell, Richard H.	Evansville	Vanderburgh
Rust, Byron K.	Indianapolis	Marion
Ruth, Martin L.	Indianapolis	Marion
Rutherford, C. W. (H)	Indianapolis	Marion
Ryan, Glen V.	Indianapolis	Marion
Ryan, H. J.	Gary	Lake
Ryan, William J.	Columbus	Bartholomew-Brown
Ryan, William J. J.	Ft. Wayne	Allen

S

Sacks, Harry J.	Indianapolis	Marion
Sage, Charles V., Jr.	Richmond	Wayne-Union
Sage, Russell	Indianapolis	Marion
Sagel, Jacob	Gary	Lake
Sahlman, Hans	Ft. Wayne	Allen
Sala, J. J.	Gary	Lake
Sala, Walter R.	Gary	Lake
Salb, Leo A.	Jasper	Dubois
Salb, Max C.	Indianapolis	Marion
Sallee, William T.	Greensburg	Decatur
Salon, Harry W.	Ft. Wayne	Allen
Salon, N. L.	Ft. Wayne	Allen
Salzman, Morris	Indianapolis	Marion
Samples, J. T.	Boonville	Warrick
Sanders, Harry M.	Indianapolis	Marion
Sanders, J. A.	Auburn	De Kalb
Sanderson, R. B.	South Bend	St. Joseph
Sandock, Isadore	South Bend	St. Joseph

Name	City	County
Sandock, Louis	South Bend	St. Joseph
Sandorf, M. H.	Indianapolis	Marion
Sandoz, Harry	South Bend	St. Joseph
Sandoz, Louis A.	South Bend	St. Joseph
Sandy, Wm. A.	Marion	Grant
Saunders, J. L.	Newport	Parke-Vermillion
Savage, A. R.	Ft. Wayne	Allen
Savery, C. E.	South Bend	St. Joseph
Sayers, F. E.	Terre Haute	Vigo
Scamahorn, Malcolm O.	Pittsboro	Hendricks
Scamahorn, O. T.	Pittsboro	Hendricks
Scea, Wallace	Elwood	Madison
Schaaf, Alvin	Jamestown	Boone
Schaefer, C. R. (H)	Indianapolis	Marion
Schaefer, William C.	Evansville	Vanderburgh
Schafer, Donald W.	Ft. Wayne	Allen
Schafer, William C.	Washington	Daviess-Martin
Schaible, E. L.	Gary	Lake
Schaie, Milton	Rockville	Parke-Vermillion
Schantz, Richard	Remington	Jasper-Newton
Schauwecker, Cleon M.	Greencastle	Putnam
Schechter, John S.	Indianapolis	Marion
Scheetz, Marion R.	Lewisville	Henry
Scheier ,E. W.	Indianapolis	Marion
Schell, Harry D.	Bloomington	Owen-Monroe
Schellhouse, Earl	Fort Wayne	Allen
Schenck, Foss	Logansport	Cass
Schenk, G. H.	Ridgeville	Randolph
Scherb, Burton E.	Terre Haute	Vigo
Scherschel, John P.	Bedford	Lawrence
Schetgen, Joseph V.	Geneva	Adams
Scheurich, Virgil	Oxford	Benton
Schick, Martin F. (H)	Ft. Wayne	Allen
Schiller, Herbert A.	South Bend	St. Joseph
Schirmer, Robert H.	Evansville	Vanderburgh
Schlademan, Karl R.	Ft. Wayne	Allen
Schlagel, T. F., Jr.	Indianapolis	Marion
Schlegel, Edward H.	Ft. Wayne	Allen
Schlemmer, George H.	Warsaw	Kosciusko
Schlesinger, Daniel	Hammond	Lake
Schlesinger, Jacob	Hammond	Lake
Schlieker, A. G. (H)	Troy, Mo.	Lake
Schlosser, H. C.	Elkhart	Elkhart
Schmidt, Eugene F.	Ft. Wayne	Allen
Schmidt, Loren F.	Indianapolis	Marion
Schmidt, Richard H.	Indianapolis	Marion
Schmiedicke, P. H.	Williamsport	Fountain-Warren
Schmitt, Richard K.	Columbus	Bartholomew-Brown
Schmoll, Robert J.	Ft. Wayne	Allen
Schneider, Carl J.	Indianapolis	Marion
Schneider, C. P.	Evansville	Vanderburgh
Schneider, Kenneth	Nashville	Bartholomew-Brown
Schneider, Louis A.	Ft .Wayne	Allen
Schoen, Frederic L.	Ft. Wayne	Allen
Schoolfield, Wm. E.	Orleans	Orange
Schott, Edward J. (H)	Terre Haute	Vigo
Schreiner, John E.	Bremen	Marshall
Schriefer, Victor V.	Evansville	Vanderburgh
Schroeder, Henry	Washington	Daviess-Martin
Schubert, Justin C.	Morocco	Jasper-Newton
Schuchman, Abe	Indianapolis	Marion
Schuchman, Gabriel	Indianapolis	Marion
Schuldt, T. S.	Pierceton	Kosciusko
Schuler, R. P.	Kokomo	Howard
Schulhof, M. G.	Muncie	Delaware-Blackford
Schulz, C. H.	LaGrange	LaGrange
Schulze, Hans A.	Indianapolis	Marion
Schulze, Wm.	Vincennes	Knox
Schumaker, Robert A.	Terre Haute	Vigo
Schuman, Edith B.	Bloomington	Owen-Monroe
Schuster, Dwight W.	Indianapolis	Marion
Schutt, J. B.	Ligonier	Noble
Schwartz, Fred C.	Kokomo	Howard
Schwartz, W. D. (H)	Portland	Jay
Schweitzer, Ada E. (H)	Indianapolis	Marion
Scoins, W. H.	Ft. Wayne	Allen
Scott, Frank M.	South Bend	St. Joseph
Scott, G. D.	Sullivan	Sullivan
Scott, George E.	Indianapolis	Marion
Scott, H. V.	Ft. Wayne	Allen
Scott, Irvin H.	Sullivan	Sullivan
Scott, I. W.	Indianapolis	Marion
Scott, John S.	Indianapolis	Marion
Scott, R. F.	Kokomo	Howard
Scott, Robert P.	Indianapolis	Marion
Scott, S. L.	Indianapolis	Marion
Scott, V. Brown	Shelbyville	Shelby
Scudder, A. N.	Brownsburg	Hendricks
Scudder, J. A.	Edwardsport	Knox
Seagle, William C.	Indianapolis	Marion
Seal, Perry F.	Brookville	Fayette-Franklin
Seale, Joseph P.	Fairmount	Grant
Seaman, C. F.	Indianapolis	Marion
Sears, Don	Odon	Daviess-Martin
Sears, M. Maywood (H)	Elkhart	Elkhart
Sedam, Herbert L.	Indianapolis	Marion
Segar, Louis H.	Indianapolis	Marion
Seglin, Robbert V.	Hammond	Lake
Seibel, Robert M.	Morgantown	Morgan
Seidell. Martin A.	Indianapolis	Marion
Seitz, P. F. D.	Indianapolis	Marion
Selby, K. E.	South Bend	St. Joseph
Sellers, Francis M.	South Bend	St. Joseph
Selsam, Etta B.	Terre Haute	Vigo
Senese, T. J.	Gary	Lake
Sennett, C. M.	South Bend	St. Joseph
Sennett, Wm. K.	Macy	Miami
Sensenich, R. L.	South Bend	St. Joseph
Senseny, Herbert	Ft. Wayne	Allen
Seward, G. W.	N. Manchester	Wabash
Sexson, Hiram	Indianapolis	Marion
Seybert, J. D.	Kendallville	Noble
Seyler, Anna G.	Crown Point	Lake
Shacklett, Henry B. (H)	New Albany	Floyd
Shafer, J. W. (H)	Lafayette	Tippecanoe
Shafer, Marion R.	Indianapolis	Marion
Shafer, Richard H.	Alexandria	Madison
Shaffer, K. L.	Vincennes	Knox
Shallenberger, H. R.	Modoc	Randolph
Shanklin, E. M. (H)	Hammond	Lake
Shanklin, V. A.	Terre Haute	Vigo
Shanks, Ray W.	Noblesville	Hamilton
Shanks, Roy E.	Rushville	Rush
Shapiro, Joseph	East Chicago	Lake
Sharman, Edward J.	Louisville, Ky.	Jefferson
Sharp, John L.	Crawfordsville	Montgomery
Sharp, W. L.	Anderson	Madison
Shattuck, John C.	Brazil	Clay
Sheehan, Francis G.	Indianapolis	Marion
Sheek, Kenneth I.	Greenwood	Johnson
Sheller, Thomas G.	Argos	Marshall
Shelley, Edward	South Bend	St. Joseph
Shellhouse, Michael	Gary	Lake
Shenk, E. M.	Kokomo	Howard
Shepard, Fred F.	College Corner, Ohio	Wayne-Union
Sheridan, Joseph L.	Wash., D. C.	Marion
Sherman, Robert M.	Cincinnati, O.	Wells
Sherster, Harry	Indianapolis	Marion
Sherwood, J. V.	Ft. Wayne	Allen
Shields, Harry A.	Washington	Daviess-Martin
Shields, Jack E.	Brownstown	Jackson
Shields, Tom S.	Richmond	Wayne-Union

Name	City	County
Shinabery, Lawerence	Ft. Wayne	Allen
Shively, John A.	South Bend	St. Joseph
Shively, John L.	Hagerstown	Henry
Sholty, W. M.	Lafayette	Tippecanoe
Shonk, Harold W.	Noblesville	Hamilton
Short, John	Ft. Wayne	Allen
Shortridge, W. H.	Seymour	Jackson
Shoup, H. B.	Greentown	Howard
Showalter, John P.	Waterloo	De Kalb
Showalter, John R.	Terre Haute	Vigo
Shrigley, Edw. W.	Indianapolis	Marion
Shrock, E. E.	Amboy	Miami
Shroyer, Herbert	Dunkirk	Jay
Shuck, Wm. A.	Madison	Jefferson
Shugart, Joseph D.	Indianapolis	Marion
Shullenberger, W. A.	Indianapolis	Marion
Shulruff, H. I.	East Chicago	Lake
Shultz, H. M. (H)	Logansport	Cass
Shumacker, H. B., Jr.	Indianapolis	Marion
Sicks, O. W.	Indianapolis	Marion
Sidebottom, Earl	Indianapolis	Marion
Siebenmorgen, Louis	Terre Haute	Vigo
Siebenmorgen, Paul	Terre Haute	Vigo
Siegman, Edw. L.	Terre Haute	Vigo
Siekerman, C. W.	Indianapolis	Marion
Siekierski, J. M.	Griffith	Lake
Siersdorfer, T. N.	Indianapolis	Marion
Sigmond, Harvey W.	Indianapolis	Marion
Sigmund, Wm. B.	Columbus	Bartholomew-Brown
Silbert, David	Shelbyville	Shelby
Silverman, Norman M.	Terre Haute	Vigo
Silver, Richard A.	Indianapolis	Marion
Silvers, J. M. (H)	Muncie	Delaware-Blackford
Silvian, Harry	Whiting	Lake
Simmons, Frederick H.	Marion	Grant
Simmons, L. H.	Goshen	Elkhart
Simms, J. Leon	Indianapolis	Marion
Simon, A. R.	La Porte	La Porte
Simons, James (H)	Lyons	Greene
Simpson, Gordon	Ft. Smith, Ark.	Tippecanoe
Simpson, Wm. D.	Indianapolis	Marion
Sims, J. Lawrence	Indianapolis	Marion
Singer, E. C.	Ft. Wayne	Allen
Sink, Frank G.	Remington	Jasper-Newton
Sirlin, E. M.	Mishawaka	St. Joseph
Sisson, Helen M.	Pendleton	Madison
Skeen, E. D.	Gary	Lake
Skillern, P. G.	South Bend	St. Joseph
Skomp, Claud E.	Marion	Grant
Skrentny, Stanley	Hammond	Lake
Slabaugh, J. S. (H)	Nappanee	Elkhart
Slama, George	Gary	Lake
Slaughter, Howard C.	Evansville	Vanderburgh
Slaughter, John	Evansville	Vanderburgh
Slaughter, Owen L.	Evansville	Vanderburgh
Slick, C. R.	Lynn	Randolph
Sloan, H. P.	New Albany	Floyd
Slominski, H. H.	South Bend	St. Joseph
Sloss, I. H.	Terre Haute	Vigo
Sluss, David H.	Indianapolis	Marion
Sluss, John W. (H)	Indianapolis	Marion
Smallwood, R. B.	Bedford	Lawrence
Smelser, H. W.	Connersville	Fayette-Franklin
Smith, B. J.	Kingman	Fountain-Warren
Smith, Charles G.	Otterbein	Benton
Smith, David J.	Indianapolis	Marion
Smith, D. L.	Indianapolis	Marion
Smith, E. Rogers	Indianapolis	Marion
Smith, Francis C.	Indianapolis	Marion
Smith, Frederick R.	Spencer	Owen-Monroe
Smith, G. A.	New Haven	Allen
Smith, Gloster J.	Kokomo	Howard
Smith, H. N.	Brookville	Fayette-Franklin
Smith, H. S.	Bloomington	Owen-Monroe
Smith, James M.	Indianapolis	Marion
Smith, James S.	Muncie	Delaware-Blackford
Smith, John R.	Richmond	Wayne-Union
Smith, L. C.	Lafayette	Tippecanoe
Smith, L. W.	Warren	Huntington
Smith, Louis D.	East Chicago	Lake
Smith, Lester A.	Indianapolis	Marion
Smith, Marsh H.	Goodland	Jasper-Newton
Smith, Paul E.	Bloomington	Owen-Monroe
Smith, Philip L.	Ft. Wayne	Allen
Smith, Ralph O.	Vincennes	Knox
Smith, Robert A.	New Castle	Henry
Smith, R. D. (H)	Bloomington	Owen-Monroe
Smith, R. Lee	Osgood	Ripley
Smith, Richard B.	New Haven	Allen
Smith, Roger C.	Rochester, Minn.	Allen
Smith, Roy L.	Indianapolis	Marion
Smith, S. Joseph	Vincennes	Knox
Smith, T. J.	Whiting	Lake
Smith, W. E. (H)	Decatur	Adams
Smith, Wilbur F.	Indianapolis	Marion
Smith, William B.	Indianapolis	Marion
Smoot, Emory B.	Washington	Daviess-Martin
Smoots, S. A.	Terre Haute	Vigo
Sneary, K. D.	Avilla	Noble
Snider, Byron	Indianapolis	Marion
Snively, W. D., Jr.	Evansville	Vanderburgh
Snyder, E. R.	Troy	Perry
Snyder, Morris C.	Richmond	Wayne-Union
Solomon, R. A.	Indianapolis	Marion
Solomon, Robert D.	Terre Haute	Vigo
Somers, G. H.	Ft. Wayne	Allen
Soper, Hunter A.	Emmettsburg, Iowa	Marion
Sorenson, Raymond	Kokomo	Howard
Sosson, Edward	Hammond	Lake
Souder, Bonnell M.	Auburn	De Kalb
Sourwine, C. C.	Brazil	Clay
Souter, Martha C.	Indianapolis	Marion
Southard, C. B.	Noblesville	Hamilton
Sovine, Joe W.	Indianapolis	Marion
Spahr, D. E.	Portland	Jay
Spahr, John F.	Indianapolis	Marion
Spalding, J. J.	Indianapolis	Marion
Spalding, W. L.	Mishawaka	St. Joseph
Spangler, Jesse S.	Kokomo	Howard
Sparks, A. Jerome	Ft. Wayne	Allen
Sparks, Alan L.	Indianapolis	Marion
Sparks, Paul W.	Winchester	Randolph
Spears, John K.	Paoli	Orange
Speas, Robert C.	Terre Haute	Vigo
Spellman, Frank A.	Gary	Lake
Spencer, Beaufort A.	Bloomington	Owen-Monroe
Spencer, Frederic	Vincennes	Knox
Spenner, R. W.	South Bend	St. Joseph
Spieth, Wm. H.	Lebanon	Boone
Spigler, James	Terre Haute	Vigo
Spindler, Robert D.	Shelbyville	Shelby
Spink, Urbana	Indianapolis	Marion
Spinning ,Alva (H)	Michigan City	LaPorte
Spivack, Mary	Gary	Lake
Spivey, R. J.	Indianapolis	Marion
Spolyar, L. W.	Indianapolis	Marion
Sponder, Joseph	Gary	Lake
Spray, Page E.	Elkhart	Elkhart
Springstun, C. E.	Tennyson	Warrick
Springstun, C. L.	Chrisney	Spencer
Springstun, George	Oaktown	Knox
Springstun, W. R.	Evansville	Vanderburgh

Name	City	County
Spurgeon, O. E.	Muncie	Delaware-Blackford
Spurlock, Fae	W. Lafayette	Tippecanoe
Sputh, Carl B., Sr.	Indianapolis	Marion
Sputh, Carl B., Jr.	Indianapolis	Marion
Sroka, Stanley J.	Highland (Hammond)	Lake
Stadler, Harold E.	Indianapolis	Marion
Staff, Robert A.	Rockville	Parke-Vermillion
Stafford, J. C.	Plainfield	Hendricks
Stafford, W. C.	Plainfield	Hendricks
Stahl, Edward	Lafayette	Tippecanoe
Stalker, John M.	Borden	Clark
Stalter, Gaylord W.	N. Webster	Kosciusko
Stamper, J. H.	Anderson	Madison
Stamper, L. Allen	Richmond	Wayne-Union
Stangle, W. J.	Bloomington	Owen-Monroe
Stanley, J. S.	Indianapolis	Marion
Stanton, J. J.	Logansport	Cass
Stapleton, Pauline	W. Lafayette	Tippecanoe
Stasick, Murray	Hammond	Lake
Stauffer, George E.	Mooreland	Henry
Stauffer, Richard C.	Ft. Wayne	Allen
Stauffer, Walter A.	Elkhart	Elkhart
Staunton, Henry A.	South Bend	St. Joseph
Stayton, C. A.	Indianapolis	Marion
Stayton, Chester A., Jr.	Indianapolis	Marion
Stecy, Peter	Whiting	Lake
Steele, Dick J.	Greencastle	Putnam
Steele, E. B.	Crown Point	Lake
Steele, Paul W.	Evansville	Vanderburgh
Steffen, A. J.	Wabash	Wabash
Steffen, J. T.	Wabash	Wabash
Steffy, Ralph M.	Portland	Jay
Steinkamp, E. F.	Huntingburg	Dubois
Steinman, H. E.	Monroeville	Allen
Stellner, Howard A.	Ft. Wayne	Allen
Stemm, W. H. (H)	North Vernon	Jennings
Stephens, Donald E.	Indianapolis	Marion
Stephens, K. H.	Indianapolis	Marion
Stephens, Lowell R.	Covington	Fountain-Warren
Stephens, R. Clarence (H)	Plymouth	Marshall
Stepleton, John D.	Richmond	Wayne-Union
Stern, Nathan	Indianapolis	Marion
Stern, S. L.	Hammond	Lake
Sterne, John H.	Evansville	Vanderburgh
Stevens, S. L.	Indianapolis	Marion
Stewart, Milton B. (H)	Logansport	Cass
Stewart, O. H.	Aurora	Dearborn-Ohio
Stewart, W. E.	Terre Haute	Vigo
Sthair, Phillip L.	Indianapolis	Marion
Stier, Paul L.	Ft. Wayne	Allen
Stillwell, William R.	Indianapolis	Marion
Stimson, H. R.	Gary	Lake
Stine, Marshall E.	Columbus, Ga.	Marshall
Stinson, A. E.	Rochester	Fulton
Stinson, Dean K.	Rochester	Fulton
Stiver, Daniel	South Bend	St. Joseph
Stocking, B. W.	Muncie	Delaware-Blackford
Stoelting, J. Lewis	Terre Haute	Vigo
Stoelting, V. K.	Indianapolis	Marion
Stogsdill, Willis	Muncie	Delaware-Blackford
Stoler, A. E.	Ft. Wayne	Allen
Stone, A. T.	Indianapolis	Marion
Stone, Charles E.	Bedford	Lawrence
Stone, David F.	Indianapolis	Marion
Stoops, Jean T.	Wabash	Wabash
Storer, Wm. R.	Hobart	Lake
Storey, D. E.	Indianapolis	Marion
Storey, Joseph L.	Indianapolis	Marion
Stork, Harvey K.	Huntingburg	Dubois
Stork, Urban	Evansville	Vanderburgh
Storms, Roy B.	Indianapolis	Marion
Stouder, Albert E.	Kempton	Tipton
Stouder, Charles E.	Gosport	Owen-Monroe
Stout, Francis E.	Indianapolis	Marion
Stout, Harry T.	Frankfort	Clinton
Stout, R. B.	Elkhart	Elkhart
Stout, Walter M.	New Castle	Henry
Stover, Wendell C.	Boonville	Warrick
Stoycoff, C. M.	Gary	Lake
Strange, Dempsey C.	Starkville, Miss.	Marion
Strange, J. W.	Loogootee	Daviess-Martin
Stratigos, Jos. S.	South Bend	St. Joseph
Straus, David C.	Michigan City	La Porte
Strayer, J. W.	Lafayette	Tippecanoe
Streck, F. A.	Lawrenceburg	Dearborn-Ohio
Strecker, Wm. L.	Terre Haute	Vigo
Streepey, J. I.	New Albany	Floyd
Strickland, Karl S.	Princeton	Gibson
Strickland, Martha B.	Lafayette	Tippecanoe
Strickland, Wm. B.	Mitchell	Lawrence
Strong, Daniel S.	Terre Haute	Vigo
Stroup, Tyler J.	Indianapolis	Marion
Stubbins, William M.	Elkhart	Elkhart
Stuckman, E. D. (H)	New Paris	Elkhart
Stucky, Ellsworth	Indianapolis	Marion
Study, Robert S.	Indianapolis	Marion
Stultz, Q. F.	Ligonier	Noble
Stump, Thomas A.	Indianapolis	Marion
Sturgis, Donald G.	Sellersburg	Clark
Stygall, James H.	Indianapolis	Marion
Sudranski, Herbert F.	Indianapolis	Marion
Sugarman, Benj. E.	French Lick	Orange
Sullenger, A. A.	Vincennes	Knox
Sullivan, John M.	Terre Haute	Vigo
Sutter, Charles C.	Evansville	Vanderburgh
Sutton, Wm. E.	Indianapolis	Marion
Suzuki, Tsutomu T.	Covington	Fountain-Warren
Swan, John R.	Indianapolis	Marion
Swan, Richard Carl	Anderson	Madison
Swank, L. Forrest	Elkhart	Elkhart
Swayne, J. F.	Indianapolis	Marion
Sweet, Howard E.	Richmond	Wayne-Union
Swihart, Homer R.	Elkhart	Elkhart
Swihart, L. F.	Elkhart	Elkhart
Switzer, Robert E.	Denver, Colorado	Noble
Symmes, Alfred T.	Indianapolis	Marion
Szynal, John S.	Indianapolis	Marion

T

Take, J. F. (H)	French Lick	Orange
Talbert, Pierre C.	Philadelphia, Pa.	Wells
Talbott, Dan E.	Indianapolis	Marion
Tanner, Henry S.	Indianapolis	Marion
Taylor, C. C.	Indianapolis	Marion
Taylor, E. C.	Upland	Grant
Taylor, Eugene C.	Evansville	Vanderburgh
Taylor, F. W.	Indianapolis	Marion
Taylor, James A. (H)	Montpelier	Delaware-Blackford
Taylor, Lon S.	Elberfeld	Warrick
Taylor, W. H.	Ambia	Benton
Taylor, W. Mitchell	Crawfordsville	Montgomery
Taylor, W. R.	Richmond	Wayne-Union
Teaford, S. F.	Paoli	Orange
Teague, Frank	Indianapolis	Marion
Teal, Dorothy D.	Columbus	Bartholomew-Brown
Teegarden, J. A., Jr.	East Chicago	Lake
Teegarden, J. A., Sr.	East Chicago	Lake
Teixler, V. A.	Indianapolis	Marion
Templeton, Ames R.	Mishawaka	St. Joseph
Templin, D. B.	Gary	Lake
Tennant, David L.	Ft. Wayne	Allen

Name	City	County
Tennis, George	Greencastle	Putnam
Teplinsky, L. Louis	Munster	Lake
Terflinger, F. W. (H)	Logansport	Cass
Terrill, R. W.	Ft. Wayne	Allen
Terry, Lloyd	Danville	Hendricks
Terry, William B. G., Jr.	Detroit, Mich.	Marion
Terveer, John B.	Decatur	Adams
Test, Charles E.	Indianapolis	Marion
Test, Pasquale S.	Indianapolis	Marion
Teter, Geo. V., Jr.	Boston, Mass.	Marion
Teters, Melvin S.	Middlebury	Elkhart
Tether, Joseph E., Jr.	Indianapolis	Marion
Tetrick, Elbert L.	Indianapolis	Marion
Tharp, Harold R.	Indianapolis	Marion
Tharpe, Ray	Indianapolis	Marion
Thatcher, H. K., Jr.	Indianapolis	Marion
Thayer, B. W.	North Vernon	Jennings
Thayer, J. O.	Noblesville	Hamilton
Thegze, George	Whiting	Lake
Thill, Leonard J.	Ashley	De Kalb
Thimlar, J. W.	Ft. Wayne	Allen
Thom, Jay W.	Indianapolis	Marion
Thom, Julia S.	Indianapolis	Marion
Thomas, C. E. (H)	Leesburg	Kosciusko
Thomas, Daniel D.	Gary	Lake
Thomas, Edward P.	Indianapolis	Marion
Thomas, Everett W.	Warsaw	Kosciusko
Thomas, Fred A.	Indianapolis	Marion
Thomas, G. A.	Lafayette	Tippecanoe
Thomas, Gerald J.	Gary	Lake
Thomas, Lowell I.	Indianapolis	Marion
Thomas, Morris E.	Indianapolis	Marion
Thompson, A. A.	Tyner	Marshall
Thompson, Chas. F.	Indianapolis	Marion
Thompson, Frank	Columbia City	Whitley
Thompson, Holland	Ft. Wayne	Allen
Thompson, John M.	South Bend	St. Joseph
Thompson, J. V.	Indianapolis	Marion
Thompson, Lewis	New Harmony	Posey
Thompson, Noah (H)	Bedford, Va.	Wabash
Thompson, Paul D.	Indianapolis	Marion
Thompson, Robert A.	South Bend	St. Joseph
Thompson, W. A.	Liberty	Wayne-Union
Thompson, Wm. R.	Winamac	Pulaski
Thornburg, Kenneth	Indianapolis	Marion
Thorne, C. E.	New Castle	Henry
Thornton, Harold C.	Indianapolis	Marion
Thornton, Maurice J.	South Bend	St. Joseph
Thornton, Walter E.	Ft. Wayne	Allen
Thrasher, John R.	Indianapolis	Marion
Thurston, H. S.	Indianapolis	Marion
Tilden, Margaret	Evansville	Vanderburgh
Tiley, George	Greenwood	Johnson
Tilka, Edward	Hammond	Lake
Tindal, E. F. (H)	Muncie	Delaware-Blackford
Tindall, George T.	Indianapolis	Marion
Tindall, Paul R.	Shelbyville	Shelby
Tindall, Wm. R.	Shelbyville	Shelby
Tinney, W. E.	Indianapolis	Marion
Tinsley, Frank W.	Indianapolis	Marion
Tinsley, W. B.	Indianapolis	Marion
Tipton, Wm. R.	Greencastle	Putnam
Tirman, Wallace S.	Bluffton	Wells
Tischer, E. Paul	Indianapolis	Marion
Titus, Charles (H)	Wilkinson	Hancock
Todd, David D.	Elkhart	Elkhart
Tomak, Milton E.	Linton	Greene
Tomlin, Hugh M.	Muncie	Delaware-Blackford
Tomlinson, C. H. (H)	Cicero	Hamilton
Topolgus, James N.	Bloomington	Owen-Monroe
Topping, M. C.	Terre Haute	Vigo
Torella, J. A.	Indianapolis	Marion
Totten, E. C. (H)	Madison	Jefferson
Toumey, Fred L.	Indianapolis	Marion
Tower, Thomas K.	Campbellsburg	Washington
Tracy, Julius R.	Anderson	Madison
Tranter, W. F.	Sharpsville	Tipton
Traver, P. C.	South Bend	St. Joseph
Travis, J. C., Jr.	Indianapolis	Marion
Tremain, M. A. (H)	Adams	Decatur
Treon, James F.	Aurora	Dearborn-Ohio
Trepagnier, Francis B.	East Chicago	Lake
Trinosky, Donald L.	Gary	Lake
Tripp, H. D.	Bloomington	Owen-Monroe
Trout, C. J.	Lafayette	Tippecanoe
Troutwine, William	Crown Point	Lake
Troy, Jack M.	Whiting	Lake
Truman, Elmer M., Jr.	Rushville	Rush
Trusler, H. M.	Indianapolis	Marion
Tubbs, George R. (H)	Lafayette	Tippecanoe
Tuchman, Joseph H.	Indianapolis	Marion
Tucker, O. A.	Daleville	Delaware-Blackford
Tucker, Robert L.	Indianapolis	Marion
Tucker, Warren S.	Indianapolis	Marion
Tully, J. A.	New Castle	Henry
Turgi, Robert W.	Gary	Lake
Turley, Verne L.	Fowler	Benton
Turner, Anna Goss	Madison	Jefferson
Turner, H. B.	Bloomfield	Greene
Turner, Jack J.	Bloomfield	Greene
Turner, John P.	Goshen	Elkhart
Turner, Maurice A.	Oakland City	Gibson
Turner, Oscar A.	Madison	Jefferson
Turner, Robert	Muncie	Delaware-Blackford
Tweedall, D. C.	Evansville	Vanderburgh
Tweedall, D. G.	Evansville	Vanderburgh
Tyler, F. T.	New Albany	Floyd
Tyner, Harlan H.	Clayton	Hendricks
Tyrrell, Thomas C.	Calumet City, Ill.	Lake

U

Uhrich, John H.	Monroeville	Allen
Underwood, G. B.	Evansville	Vanderburgh
Urschel, Dan L.	Mentone	Kosciusko
Utterback, Arnold	Terre Haute	Vigo

V

Vagner, Bernard	South Bend	St. Joseph
Vail, George A.	Lawrenceburg	Dearborn-Ohio
VanArsdall, C. R.	Terre Haute	Vigo
VanBokkelen, Robert	Mooresville	Morgan
Van Buskirk, E. L.	Lafayette	Tippecanoe
Vance, Wm. C.	Richmond	Wayne-Union
VanderBogart, H. E.	Goshen	Elkhart
Vandevert, Arthur	Sellersburg	Clark
Vandivier, R. M.	Indianapolis	Marion
VanDorn, Myron J.	Indianapolis	Marion
VanFleet, Josephine	Indianapolis	Marion
Van Kirk, George H.	Kentland	Jasper-Newton
VanKirk, J. A.	Frankfort	Clinton
VanKirk, John R.	Burlington	Carroll
VanKirk, Paul P.	Frankfort	Clinton
VanMeter, C. Powell	Indianapolis	Marion
VanNess, William C.	Summitville	Madison
VanNest, W. A.	New Smyrna Beach, Fla.	Dekalb
Van Nuys, John D.	Indianapolis	Marion
VanNuys, W. C.	New Castle	Henry
VanOsdol, H. A.	Indianapolis	Marion
Van Rie, L. P.	Mishawaka	St. Joseph
Van Sandt, Frank A.	Bloomfield	Greene
VanTassel, Charles J.	Indianapolis	Marion
VanVactor, Helen D.	Indianapolis	Marion
VanWinkle, Arthur J.	Valparaiso	Porter

Name	City	County
Veach, Lester W.	Bainbridge	Putnam
Veach, Richard L.	Bainbridge	Putnam
Veazey, Wm. (H)	Avilla	Noble
Venable, George L.	N. Manchester	Wabash
Venis, Kemper N.	Muncie	Delaware-Blackford
Vermilya, R. W.	Lafayette	Tippecanoe
Verplank, G. L.	Gary	Lake
Viehe, Robert W.	Evansville	Vanderburgh
Vietzke, P. C. F.	Valparaiso	Porter
Vingus, Bronie	Greenfield	Hancock
Viney, Charles L.	Logansport	Cass
Visher, John S.	St. Paul, Minn.	Vanderburgh
Visher, John W.	Evansville	Vanderburgh
Vlaskamp, Elaine	Muncie	Delaware-Blackford
Vogel, L. John	Mt. Vernon	Posey
Voges, Edward C.	Terre Haute	Vigo
Voisinet, R. A.	Union City	Randolph
Vollrath, Victor J.	Indianapolis	Marion
VonAsch, George	LaPorte	LaPorte
Vore, Hugh A.	East Chicago	Lake
Vore, L. W.	Plymouth	Marshall
Voyles, C. F. (H)	Indianapolis	Marion
Voyles, Harry	New Albany	Floyd
Vracin, Daniel J.	Downey, Calif.	Lake
Vurpillat, Francis J.	South Bend	St. Joseph
Vye, James P.	Gary	Lake
	W	
Wade, A. A.	Howe	LaGrange
Wagner, Arthur L.	Jasper	Dubois
Wagoner, G. W.	Delphi	Carroll
Wagoner, John B.	Colburn	Tippecanoe
Wagoner, Robert H. (H)	Colburn	Tippecanoe
Waite, Earl L.	Macy	Miami
Waite, Richard R.	Lafayette	Tippecanoe
Waits, Chester L.	Colfax	Clinton
Waldo, J. Thayer	Indianapolis	Marion
Walerko, Frank	Mishawaka	St. Joseph
Wales, E. DeWolfe (H)	Indianapolis	Marion
Walker, Adolph B.	Whiting	Lake
Walker, F. C.	Indianapolis	Marion
Walker, Floyd	Fort Wayne	Allen
Walker, Jack M.	Knightstown	Henry
Walker, J. L.	LaFontaine	Wabash
Walker, Robert K.	Indianapolis	Marion
Wall, Joseph A.	Owensboro, Ky.	Wabash
Wallace, Hawthorne C.	Crawfordsville	Montgomery
Waller, John I.	Indianapolis	Marion
Walters, Charles E.	Mishawaka	St. Joseph
Walters, William	Michigan City	LaPorte
Walther, Joseph E.	Indianapolis	Marion
Wanninger, Horace	Richmond	Wayne-Union
Ward, H. H. (H)	Coalmont	Clay
Ward, J. W.	Mishawaka	St. Joseph
Ward, Jos. H.	Indianapolis	Marion
Ward, Wesley C.	Indianapolis	Marion
Ware, J. R.	Huntington	Huntington
Warfel, F. C.	Indianapolis	Marion
Warfield, Chester H.	Ft. Wayne	Allen
Warman, A. P.	Indianapolis	Marion
Warn, William J.	Milan	Ripley
Warne, G. H.	Tipton	Tipton
Warren, Bradford	Marshall	Parke-Vermillion
Warren, Carroll B.	Marion	Grant
Warren, John C.	Indianapolis	Marion
Warrick, Francis B.	Richmond	Wayne-Union
Warrick, Homer L.	Osceola	St. Joseph
Warriner, James B.	Indianapolis	Marion
Warvel, J. H.	Indianapolis	Marion
Warvel, Joseph L. (H)	N. Manchester	Wabash
Washburn, W. W.	Lafayette	Tippecanoe
Washington, G. Kenneth	Gary	Lake
Wasley, Malcolm T.	Whittier, Cal.	Delaware-Blackford
Waterman, John H.	Indianapolis	Marion
Watterson, Gerald T.	Connersville	Fayette-Franklin
Waymire, E. S.	Indianapolis	Marion
Weaver, T. M. (H)	Brazil	Clay
Weaver, Wm. W.	New Albany	Floyd
Webb, Harry D.	Anderson	Madison
Weber, Edgar H.	Evansville	Vanderburgh
Weber, John R.	Ft. Wayne	Allen
Weber, Joseph G. S.	Terre Haute	Vigo
Webster, R. K.	Brazil	Clay
Weddle, Chas. O.	Lebanon	Boone
Weeks, P. H.	Michigan City	LaPorte
Weems, M. P.	Jeffersonville	Clark
Wegner, William G. (H)	South Bend	St. Joseph
Wehrman, J. O. (H)	Indianapolis	Marion
Weigand, C. G.	Indianapolis	Marion
Weil, H. J.	Indianapolis	Marion
Weinberg, B. A.	Whiting	Lake
Weinberg, Samuel	Marion	Grant
Weinland, George C.	Indianapolis	Marion
Weinstein, E. B.	Richmond	Wayne-Union
Weinstein, J. H.	Terre Haute	Vigo
Weinstock, Adolph	Rolling Prairie	LaPorte
Weir, Dale	LaGrange	LaGrange
Weirich, Charles I.	Butler	Dekalb
Weis, William D. (H)	Crown Point	Lake
Weiskopf, Henry S.	Gary	Lake
Weiss, Eugene	South Bend	St. Joseph
Weiss, H. G.	Evansville	Vanderburgh
Weiss, Jason	Indianapolis	Marion
Weitzel, Roland	Princeton	Gibson
Welborn, Mell B.	Evansville	Vanderburgh
Welch, Norbert M.	Vincennes	Knox
Weldy, Bryce P.	Hartford City	Delaware-Blackford
Weller, Charles A.	Indianapolis	Marion
Welsh, John B.	Madison	Anderson
Welty, S. G.	Ft. Wayne	Allen
Werry, L. E.	Hartford City	Delaware-Blackford
Wertenberger, Morris D.	Richmond	Wayne-Union
Wesson, Thomas W.	Evansville	Vanderburgh
West, Joseph L.	Indianapolis	Marion
Westfall, B. Kemper	Indianapolis	Marion
Westfall, George S.	Goshen	Elkhart
Westfall, John B.	Indianapolis	Marion
Weyerbacher, A. F.	Indianapolis	Marion
Whallon, Arthur J.	Richmond	Wayne-Union
Wharton, R. O.	Gary	Lake
Wheeler, J. T. (H)	Indianapolis	Marion
Whipps, Charles E.	Carlisle	Sullivan
Whisler, F. M.	Wabash	Wabash
Whitcomb, Roger F.	Shelbyville	Shelby
White, C. S.	Rosedale	Parke-Vermillion
White, Donald J.	Indianapolis	Marion
White, Harvey E.	Farmland	Randolph
White, I. D. (H)	Clinton	Parke-Vermillion
White, James V.	Terre Haute	Vigo
White, Philip T.	Indianapolis	Marion
White, W. J. (H)	Gary	Lake
Whitehead, John M.	Indianapolis	Marion
Whitlock, Francis C.	Indianapolis	Marion
Whitlock, Merle E.	Mishawaka	St. Joseph
Whitsitt, S. A. (H)	Madison	Jefferson
Whitt, James D.	Chattanooga, Tenn.	Marion
Witt, William R.	New Albany	Floyd

Name	City	County
Wicks, O. C. (H)	Gary	Lake
Wiedemann, F. E. (H)	Terre Haute	Vigo
Wiethoff, Clifford Allen	Seymour	Jackson
Wiggins, D. S. (H)	New Castle	Henry
Wiggins, George	New Castle	Henry
Wilber, H. R.	Jeffersonville	Clark
Wilcox, R. F.	LaPorte	LaPorte
Wilder, G. B.	Anderson	Madison
Wildman, R. E.	Peru	Miami
Wiley, William M.	Shelbyville	Shelby
Wilhelm, Agatha M.	South Bend	St. Joseph
Wilhelmus, C. Kenneth	Evansville	Vanderburgh
Wilhelmus, Charles M.	Newburgh	Warrick
Wilhelmus, Gilbert	Evansville	Vanderburgh
Wilhelmus, Wm. M.	Evansville	Vanderburgh
Wilkens, I. W.	Indianapolis	Marion
Wilkerson, Edward L.	Terre Haute	Vigo
Wilkins, R. W.	Ft. Wayne	Allen
Wilkinson, Roger L.	Anderson	Madison
Willan, H. R.	Martinsville	Morgan
Williams, A. H.	Ft. Wayne	Allen
Williams, Alexander S.	Gary	Lake
Williams, Berniece	Ft. Wayne	Allen
Williams, Charles D.	Indianapolis	Marion
Williams, C. L.	Lexington, Ky.	Grant
Williams, Everett W.	Columbus	Bartholomew-Brown
Williams, F. M., Jr.	Anderson	Madison
Williams, F. P.	Huntingburg	Dubois
Williams, Frederic N.	Mt. Vernon	Posey
Williams, H. O.	Kendallville	Noble
Williams, H. S., Jr.	Indianapolis	Marion
Williams, Hugh L.	Indianapolis	Marion
Williams, John H.	Muncie	Delaware-Blackford
Williams, Luther (H)	Indianapolis	Marion
Williams, Paul D.	Richmond	Wayne-Union
Williams, Robert D.	Markleville	Madison
Williams, R. H.	Anderson	Madison
Willis, Charles F.	Evansville	Vanderburgh
Willison, George	Evansville	Vanderburgh
Willner, Alan	Clarksville	Clark
Wills, Benjamin F.	Union City	Randolph
Wills, Max	Auburn	DeKalb
Willson, C. L.	Anderson	Madison
Wilmore, Ralph C.	Indianapolis	Marion
Wilson, Fred	Terre Haute	Vigo
Wilson, Fred M.	Indianapolis	Marion
Wilson, Guy	Bicknell	Knox
Wilson, James	South Bend	St. Joseph
Wilson, John D.	Evansville	Vanderburgh
Wilson, Leslie	Ft. Wayne	Allen
Wilson, O. E.	Elkhart	Elkhart
Wilson, Oliver R.	Indianapolis	Marion
Wilson, Paul	Boonville	Warrick
Wilson, P. H.	Logansport	Cass
Wilson, R. C.	Franklin	Johnson
Wilson, Ralph	Evansville	Vanderburgh
Wilson, Ralph (H)	Shirley	Henry
Wilson, Roland B.	Ft. Wayne	Allen
Wilson, T. L.	Bloomington	Owen-Monroe
Wiltshire, J. W. (H)	Bloomington	Owen-Monroe
Wimmer, Robert N.	Gary	Lake
Winter, Donald K.	Logansport	Cass
Winters, Matthew	Indianapolis	Marion
Wise, Charles L.	Camden	Carroll
Wise, Wm.	Indianapolis	Marion
Wiseheart, O. H. (H)	North Salem	Hendricks
Wiseheart, Robert	Lebanon	Boone
Wiseman, V. Earle	Greencastle	Putnam
Wisener, G. H.	Richmond	Wayne-Union
Wishard, Wm. N., Jr.	Indianapolis	Marion
Wishart, S. W.	Evansville	Vanderburgh
Wissman, William L.	Columbus	Bartholomew-Brown
Witham, Robert L.	Culver	Marshall
Wixted, John F.	Mishawaka	St. Joseph
Wixted, Julia F.	Mishawaka	St. Joseph
Wohlfeld, Gerald	New Albany	Floyd
Wohlfeld, J. B.	Bedford	Lawrence
Wolfe, Nelson	New Albany	Floyd
Wolfram, Don J.	Indianapolis	Marion
Woner, John W.	Linton	Greene
Wood, Amelia T.	Muncie	Delaware-Blackford
Wood, Donald E.	Indianapolis	Marion
Wood, Frederick H.	Hammond	Lake
Wood, Opal L.	Brazil	Clay
Wood, R. W.	Oakland City	Gibson
Wood, W. H.	Evansville	Vanderburgh
Woodard, Abram S., Jr.	Indianapolis	Marion
Woodcock, C. E.	Greenwood	Johnson
Woods, A. L.	Poseyville	Posey
Woods, H. C.	Markle	Huntington
Woods, James R.	Greenfield	Hancock
Woods, Wm. P.	Evansville	Vanderburgh
Woolery, R. H.	Bedford	Lawrence
Work, Bruce A.	Frankfort	Clinton
Work, James A., Jr.	Elkhart	Elkhart
Worley, A. C.	Ft. Wayne	Allen
Worley, J. P.	Indianapolis	Marion
Worley, Richard H.	Indianapolis	Marion
Worth, C. W.	Milroy	Rush
Wright, Cecil S.	Anderson	Madison
Wright, J. Wm., Jr.	Indianapolis	Marion
Wright, J. William	Indianapolis	Marion
Wright, W. C.	Ft. Wayne	Allen
Wurster, H. C.	Mishawaka	St. Joseph
Wyatt, Fred H.	Denver, Colorado	Vanderburgh
Wyatt, James L., II	Ft. Wayne	Allen
Wyatt, James L., III	Ft. Wayne	Allen
Wyeth, Charles (H)	Terre Haute	Vigo
Wygant, M. D.	Mishawaka	St. Joseph
Wyland, B. J.	Mishawaka	St. Joseph
Wynn, J. F.	Evansville	Vanderburgh
Wynne, R. E.	Bedford	Lawrence
Wyttenbach, Frederick	Indianapolis	Marion
Wyttenbach, John E.	Indianapolis	Marion

Y

Yarling, J. E. (H)	Peru	Miami
Yarrington, C. W.	Gary	Lake
Yeck, Charles W.	Evansville	Vanderburgh
Yegerlehner, Roscoe	Kentland	Jasper-Newton
Yencer, M. W. (H)	Richmond	Wayne-Union
Yochem, August S., Jr.	Chelsea, Mass.	Marion
Yocum, Paul S.	Gary	Lake
Yocum, William S.	Gary	Lake
Yoder, Albert C.	Goshen	Elkhart
Yoder, D. D.	Columbus	Bartholomew-Brown
Yoder, C. Richard	Elkhart	Elkhart
Yoder, Richard P.	Bluffton	Wells
York, Arthur F.	Anderson	Madison
Young, C. Curtis	Evansville	Vanderburgh
Young, E. M. (H)	Sheridan	Hamilton
Young, G. M.	Gary	Lake
Young, G. S.	Muncie	Delaware-Blackford
Young, James W.	Indianapolis	Marion
Young, John M.	Indianapolis	Marion
Young, Ralph H.	Goshen	Elkhart
Young, Robert	Marion	Grant
Young, S. J. (H)	Kendallville	Noble

Name	City	County
Young, W. C.	Indianapolis	Marion
Yung, J. Rudolph	Terre Haute	Vigo
Yunker, P. E.	Evansville	Vanderburgh
Z		
Zalac, Donald	Indianapolis	Marion
Zallen, Stanley G.	East Chicago	Lake
Zaring, B. K.	Columbus	Bartholomew-Brown
Zehr, Noah	Ft. Wayne	Allen
Zeiger, Irvin	South Bend	St. Joseph
Zell, Evertson H.	Indianapolis	Marion
Zeman, Theodore C.	Hammond	Lake
Zeps, E. Frances	Indianapolis	Marion
Zerfas, Charles P. A.	Indianapolis	Marion
Zerfas, L. G.	Camby	Marion
Zerfas, Phyllis	Indianapolis	Marion
Zierer, R. O.	Anderson	Madison
Zimmer, Henry J.	Mishawaka	St. Joseph
Zimmerman, Harold	Evansville	Vanderburgh
Zimmerman, Wm. H.	Dublin	Wayne-Union
Zink, Robert O.	Madison	Jefferson
Ziperman, H. Haskell	Fort Dix, N. J.	Marion
Zivich, John M.	East Chicago	Lake
Zweig, E. S.	Ft. Wayne	Allen
Zwerner, Paul F.	Terre Haute	Vigo
Zwick, Harold F.	Decatur	Adams
Zwickel, R. E.	Cleveland, O	Warrick

ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the counties in which they reside.

(Paid up members of the Indiana State Medical Association as of June 1, 1951)

ADAMS COUNTY

Beaver, Norman .....Berne
Habegger, Myron L.....Berne
Jones, D. D. (H).....Berne
Lehman, Harold .....Berne
Reusser, Amos (H) .....Berne
Burk, James M. .....Decatur
Carroll, John C. .....Decatur
Duke, Benjamin E.....Decatur
Girod, Arthur H. .....Decatur
Kohne, Gerald J. .....Decatur
Parrish, Richard K. .....Decatur
Rayl, Claudius C. .....Decatur
Reppert, Roland L. .....Decatur
Smith, Waldo E. (H).....Decatur
Terveer, John B. .....Decatur
Zwick, Harold F. .....Decatur
Hinchman, Clarence P.....Geneva
Schetgen, Joseph V. .....Geneva

ALLEN COUNTY

Fort Wayne

A

Aiken, Arthur F.....1923 E. State
Aiken, Nevin E....1923 E. State St.

B

Bailey, Paul P.
206 Wayne Phar. Bldg. (2)
Baltes, Jos. H....721 Broadway (2)
Bartholomew, Alfred C.
405 Dime Bank Bldg. (2)
Bash, Wallace E.....111 Esmond
Baumgartner, J. C.
515 W. Wayne St. (2)
Beams, Ralph
517 Wayne Phar. Bldg. (2)
Beierlein, Karl M.
629 Wayne Phar. Bldg. (2)
Benninghoff, D. R.
208 Wayne Phar. Bldg. (2)
Berghoff, R. J., 306 E. Jefferson (2)
Bickel, J. E. (H)
2615 S. Lafayette (2)
Blosser, H. V. (H) .309 W. Main (2)
Bolman, Ralph M...717 Broadway
Borders, Theodore R.
1145 S. Lafayette (2)
Bowers, G. T...307 E. Jefferson (2)
Bowers, J. W.....418 Gettle Bldg.
Brosius, R. H. W....1603 Wells (7)
Brown, F. W...335 Lincoln Bk. Tr.
Bruggeman, H. O.
604 Wayne Phar. Bldg. (2)
Bryan, Franklin A.
402 W. Washington Blvd.
Buckner, Doster
533 W. Washington St.
Buckner, George D.
533 W. Washington St.
Bulson, Eugene L.
102 Wayne Phar. Bldg. (2)

C

Calvin, J. C. (H) .312 W. Wayne (2)
Cameron, Don F.
702 Wayne Phar. Bldg. (2)
Carey, Willis W. (H)
2525 S. Calhoun (5)
Carlo, E. R.....2902 Fairfield (6)
Cartwright, E. L.
230 Wayne Phar. Bldg. (2)
Catlett, M. B....232 W. Wayne (2)
Chambers, A. R..601 W. Wayne (2)
Clark, W. R....3622 S. Calhoun St.
Conley, J. E.....620 W. Berry (2)
Cooney, C. J.....527 W. Berry (2)
Cornell, B. S....435 Lincoln Bk. Tr.
Craig, R. M...116 W. Rudisill Blvd.
Culp, J. E.....2902 Fairfield (6)

D

Dancer, C. R. (H)
905 Columbia Ave.
Datzman, Richard C.
525 Wayne Pharm. Bldg. (2)
Ditton, I. W.(H).1214 E. Wayne (4)
Duemling, A. H..2902 Fairfield (2)
Dunstone, H. C.
502 Wayne Phar. Bldg. (2)

E

Edlavitch, B. M....716 Rockhill (2)
Elston, Lynn W.
622 Wayne Phar. Bldg. (2)
Elston, Ralph W.
622 Wayne Phar. Bldg. (2)
Estlick, R. E.
629 Wayne Phar. Bldg. (2)

F

Fichman, A. M...323 W. Berry (2)
Foy, H. W.....1747 Wells St.

G

Garton, H. W.....1635 Broadway
Gerding, W. J....2638½ S. Calhoun
Gessler, W. F....2902 Fairfield (6)
Gladstone, N. H...335 W. Berry (2)
Glock, H. E.
324 Wayne, Pharm. Bldg. (2)
Glock, M. E.....312 W. Wayne (2)
Glock, W. R..335 Lincoln Bk. Tower
Goebel, Carl W.
213 W. Jefferson St.
Gould, L. K....3415 S. Fairfield (6)
Graham, George M.
Lincoln Nat. Life Ins. Co.

H

Haffner, H. G. 202 E. Jefferson (2)
Haller, Robert L.
604 W. Wayne St.
Hamilton, E. D.
2405 Florida Dr. (3)
Harshman, L. P.
2704 N. Clinton (3)
Harvey, H. C.....1202 E. State (3)
Hasewinkle, A. M..1129 E. State (3)
Hastings, Warren C..811 Ewing St.
Hattendorf, A. P.
725 Wayne Phar. Bldg. (2)
Havens, R. E.
1845 Kensington Blvd.
Hiatt, Russell L..Veterans Hospital
Hoffman, A. F.....233 E. Jefferson
Hoffmann, S. P.
424 Wayne Phar. Bldg. (2)
Holsinger, Robert E.
4617 Indiana Ave.
Horton, G. R.....527 W. Berry St.
Howe, F. L.....1525 Oxford St.

ALLEN COUNTY

(Fort Wayne—Continued)

J-K

Jackson, John F...617 Forest Ave.
Jurgensen, W. T....3415 Fairfield
Keck, Carleton A.
2902 Fairfield Ave. (2)
Kent, Richard N.
731 Wayne Phar. Bldg. (2)
Kidder, O. T.....Irene Byron San.
Kissinger, Charles C.
Veterans Hospital
Kruse, E. H....705 Lincoln Tr. (2)
Kruse, Walter E.
512 Wayne Phar. Bldg. (2)

L

Ladig, D. S.....337 E. Berry (2)
Lehner, J. J.
323 Wayne Phar. Bldg. (2)
Leming, Ben L.
1135 Lincoln Bank Bldg.
Lemons, James A.
307 Strauss Bldg.
Lenk, G. G.....2007 Maumee (4)
Lohman, R. M.
229 Wayne Phar. Bldg. (2)
Loudermilk, Jack L.
525 Wayne Phar. Bldg. (2)

M

Mackel, Frederick O.
335 Lincoln Bank Bldg.
McArdle, E. G..2201 S. Calhoun (5)
McCabe, T. E.....803 S. Calhoun
McCallister, John W.
307 Strauss Bldg.
McCoy, R. R...3701 S. Harrison (6)
McDowell, G. A.
215 Wayne Phar. Bldg. (2)
McEachern, Cecil G.
701 Wayne Phar. Bldg (2)
McFall, J. R. S.....1706 Sherman
McKeeman, Donald H.
633 W. Wayne St. (2)
McKeeman, L. S.
304 Wayne Phar. Bldg. (2)
McNairy, Donald J.
710 Wayne Phar. Bldg. (2)
Mendenhall, Edgar
208 Wayne Phar. Bldg. (2)
Mercer, Samuel R.
710 Wayne Phar. Bldg. (2)
Meyer, H. A....1030 W. Wayne (2)
Meyer, T. O.
228 Wayne Phar. Bldg.
Michaelis, S. C...2154 Fairfield (6)
Miller, C. G.....320 W. Wayne (2)
Miller, H. Paul.....2809 Broadway
Miller, Mahlon F.
334 Wayne Phar. Bldg. (2)
Miller, O. J.....324 W. Berry (2)
Miller, R. H.....511 W. Wayne (2)
Miller, W. J.....310 E. Washington
Moats, C. F....4007 S. Wayne (6)
Moats, G. E. 615 E. Washington St.
Moravec, A. E..705 Lincoln Tr. (2)
Mortenson, L. J.
214 Wayne Phar. Bldg. (2)
Mueller, L. W.....533 W. Wash.
Murdock, H. L.
521 Wayne Phar. Bldg. (2)

N-O

Nahrwold, E. W.
417 Wayne Phar. Bldg. (2)
Nill, J. H.....1024 S. Barr (2)
O'Rourke, C.....604 W. Berry (2)
Oyer, J. H....2707½ S. Calhoun St.

P

Painter, Donald S.
222 Wayne Phar. Bldg (2)
Parker, C. B...1105 S. Harrison St.
Perrin, K. F...2701 S. Anthony St.
Perry, F. G.....2902 Fairfield (6)
Phillips, John F..3148 S. Hanna St.
Popp, Milton F.
610 Wayne Phar. Bldg. (2)
Porter, Miles F., Jr.
501 Dime Bank Bldg. (2)
Prentiss, Nelson H.
276 Central Bldg. (2)

Q-R

Rabson, S. M.....730 W. Berry St.
Ranke, John W. Henry (H)
3112 Beaver Ave. (6)
Rawles, L. T.....3131 Fairfield (6)
Ray, Herbert A.
402 Wayne Phar. Bldg. (2)
Rice, W. B.....1101 E. Pontiac (5)
Rissing, W. J..... 3200 Irvington
Rockey, N. A.....1224 E. State (3)
Rodriguez, J...2902 S. Fairfield (6)
Roser, A. J.....617 W. Washington
Rossiter, D. L....103½ E. Pontiac
Rothberg, Maurice
712 Wayne Phar. Bldg. (2)
Rothschild, C. J.
319 Wayne Phar. Bldg. (2)
Ryan, W. J. J.....1536 S. Calhoun

S

Sahlmann, H...1320 Broadway (2)
Salon, H. W.....535 W. Berry (2)
Salon, Nathan L.
220 Wayne Phar. Bldg. (2)
Savage, A. R.....302 W. Berry (2)
Schafer, D. W....221 W. Wayne St.
Schellhouse, Earl....1240 W. Main
Schick, Martin F. (H)
401 W. Washington (2)
Schlademan, Karl R.
516 Wayne Phar. Bldg. (2)
Schlegel, Edward H..1129 Maumee
Schmidt, Eugene E.
1845 Forest Park Blvd.
Schmoll, R. J.....604 W. Berry St.
Schneider, L. H..St. Joseph's Hosp.
Schoen, Frederic L.
604 W. Wayne St.
Scoins, W. H.....1301 S. Harrison
Scott, H. V.....2902 Fairfield (6)
Senseny, Herbert
314 Wayne Phar. Bldg. (2)
Sherwood, J. V.
Irene Byron Sanitarium
Shinabery, L....1850 Broadway (6)
Short, J. T.....2902 Fairfield (6)
Singer, Elmer C.
310 Wayne Phar. Bldg. (2)
Smith, Philip L.
2902 Fairfield (6)
Somers, Gerald H.
2506 Lower Huntington Rd. (8)
Sparks, A. Jerome..Veterans Hosp.
Stauffer, R. C.
618 Wayne Phar. Bldg. (2)
Stellner, H.....324 W. Berry St.
Stier, Paul L.
304 Wayne Phar. Bldg. (2)
Stoler, A. E.....278 Central Bldg.

T

Tennant, D. L.....1832 S. Calhoun
Terrill, R. W....455 Lincoln Tr. (2)
Thimlar, J. W.....602 E. Lewis (2)
Thompson, H.....Irene Byron San.
Thornton, Walter E.
Lincoln Nat. Life Ins. Co.

W

Walker, Floyd B....610 E. Pontiac
Warfield, C. H....St. Joseph Hosp.
Weber, John R.
519 Wayne Phar. Bldg.
Welty, S. G..2702½ S. Calhoun (5)
Wilkins, R. W....2902 Fairfield (6)
Williams, A. B..3526 N. Wash. Rd.
Williams, A. H...2902 Fairfield (6)
Wilson, Leslie .....Veterans Hosp.
Wilson, R. B..1207 S. Lafayette (2)
Worley, Ansel C.
317 Wayne Phar. Bldg. (2)
Wright, Wm. C.
621 Wayne Phar. Bldg. (2)
Wyatt, James L. III
339 W. Berry St.
Wyatt, J. L. II.233 E. Jefferson (2)

X-Y-Z

Zehr, Noah...301 W. Creighton (6)
Zweig, E. S.....344 W. Berry (2)

Emme, Richard W. .....Harlan
Steinman, Henry E.....Monroeville
Uhrich, John .....Monroeville
Dahling, C. W.....New Haven
Emenhiser, Donald C...New Haven
Emenhiser, John L.....New Haven
Hoetzer, Eldore M.....New Haven
Smith, Grover A.....New Haven
Smith, Richard B.....New Haven
DeVoe, Kenneth .....Woodburn
Moser, Edward (H)
Box 65, Woodburn
Draper, Merlin H.
R. 4, Box 695, Tampa, Fla.
Ferguson, Arthur N.
Veterans Hosp.,
Little Rock, Ark.
Havice, Jay F.
Millbrook No. 56, Lake Lure, N.C.
Lloyd, Robert P.
2350 Secone Rd., Secone, Pa.
Smith, Roger C.
Mayo Clinic, Rochester, Minn.

BARTHOLOMEW-BROWN COUNTIES

Columbus

Adler, David L.
Bartholomew County Hospital
Beggs, Lowell F.
633 Washington St.
Lloyd, Robert P.
2350 Secone Rd., Secone, Pa.
Smith, Roger C.
Mayo Clinic, Rochester, Minn.
Carpenter, Thomas D.
725 Washington St.
Davis, Marvin R.
814 Washington St.
Fisher, Walter S.....422 9th St.
Hart, Robert B.
712 Washington St.
Hawes, James K. (H)
725 Washington St.
Hawes, Marvin E.
633 Washington St.

BARTHOLOMEW-BROWN COUNTIES

(Columbus—Continued)

Henry, Alvin L...621 Franklin St.
Macy, George W.
633 Washington St.
Marr, Griffith..741 Washington St.
Norton, Harold J.
633 Washington St.
O'Bryan, Richard B..326 16th St.
Overshiner, Lyman
633 Washington St.
Ritteman, George W.
Bartholomew County Hospital
Ryan, William J.
641 Washington St.
Schmitt, Richard K.
437 Washington St.
Sigmund, William B...522 7th St.
Teal, Dorothy Denzle
728 Franklin St.
Williams, Everett W.
725 Washington St.
Wissman, William L.
725 Washington St.
Yoder, Dewey D.
725 Washington St.
Zaring, Byron K.
718 Washington St.

Dudding, Joseph E.....Hope
Schneider, Kenneth.....Nashville

BENTON COUNTY

Taylor, Wade H.....Ambia
Atkinson, Charles W.....Boswell
Leak, Robert .....Boswell
Altier, William H.....Fowler
Turley, Verne L.....Fowler
McCabe, James E. (H)..Otterbein
Smith, Charles G.....Otterbein
Parker, Ernest E. (H).....Oxford
Scheurich, Virgil .....Oxford

BLACKFORD COUNTY

(See Delaware-Blackford)

BOONE COUNTY

Riley, Frank H. (H)...Jamestown
Schaaf, Alvin D.....Jamestown
Ballard, Robert J.....Lebanon
Beck, Herma A.....Lebanon
Coons, John D.....Lebanon
Coons, Ritchie .....Lebanon
Headley, Lloyd M.....Lebanon
Honan, Paul R.....Lebanon
Kern, Clarence G.....Lebanon
Porter, Jack .....Lebanon
Porter, John R.....Lebanon
Rainey, Everett A.....Lebanon
Spieth, William H.....Lebanon
Weddle, Charles O.....Lebanon
Wiseheart, Robert H.....Lebanon
Bassett, Clancy .....Thorntown
Bassett, Margaret A....Thorntown
Gregg, Edwin E.....Thorntown
Bailey, Lawrence S.....Zionsville
Harvey, Ralph J.....Zionsville
Johns, Elmer.....Zionsville
Lovett, Harvey .....Whitestown

BROWN COUNTY

(See Bartholomew-Brown)

CARROLL COUNTY

VanKirk, John R.....Burlington
Kennedy, Eva N.....Camden
Wise, Charles L.....Camden
Brown, Thomas .....Delphi
Crampton, Charles C. (H)..Delphi
Wagoner ,George W.....Delphi
Adams, Max R.....Flora
Brookie, Roger Wm.....Flora
McLaughlin, James R.....Flora

CASS COUNTY

Dutchess, C. Toney.....Galveston

Logansport

Adamski, Michael....408 North St.
Bailey, Earl W.....212 Fifth St.
Ballard, Chas. A...325½ E. Market
Bradfield, John C.....408 North St.
Cooper, Thomas L...408 North St.
Davis, John C.....Masonic Temple
Fitzgerald, Brice E.
Masonic Temple
Hall, Bernard R.....415 North St.
Hedde, Eugene L...309 Seventh St.
Hillis, Lowell J.....203 S. Third
Hochhalter, M....307 Barnes Bldg.
Hogle, F. D...Logansport St. Hosp.
Holloway, W. A. (H) 201 North St.
Holmes, W. W.....Masonic Temple
Jewell, Earl B.....3019 S. Penn St.
Jones, J. Carl.....422 North St.
Keefe, Thomas L.....216 Ninth St.
Larson, John A.....State Hosp.
Lemon, H. K.....State Hosp.
Maxwell, John B. (H)
431½ E. Broadway
Morrical, Russell S...212 Fifth St.
Morrow, George W.....State Hosp.
O'Leary, F. T....94 Eel River Ave.
Pfuetze, Max.....State Hosp.
Schenk, Foss Logansport St. Hosp.
Shultz, Henry M. (H)
412 Fourth St.
Stanton, Jas. J.....220 S. Sixth St.
Stewart, Milton B. (H)
308½ Fourth St.
Terflinger, Fred W. (H)
422 North St.
Viney, Charles L...Masonic Temple
Wilson, Paul H.....422 North St.
Winter, Donald K....422 North St.

Newcomb, Wm. K....Royal Center
Flanagan, Estle P.....Walton
Lybrook, Daniel E..Young America

CLARK COUNTY

Stalker, John M.....Borden
Bottorff, David .....Charlestown
Goodman, Eli .....Charlestown
Patterson, Cecil .....Charlestown
Willner, Alan .....Clarksville
Greene, William R.....Henryville

Jeffersonville

Adair, Samuel L..111 W. Court St.
Baldwin, J. H.....425 Meigs Ave.
Bizer, Mier.....402 Spring St.
Bruner, Ralph W....437 Spring St.
Buckley, Ernest P.
14 Blanche Terrace
Carlberg, Dale.....442 Spring St.
Carney, Joel T.....344 Spring St.
Clark, William B., Jr.
205 Lindley Bldg.
Dare, Lee A.....209 E. Maple St.
Forsee, Norman E...456 Spring St.
Huoni, John S.....105 W. Maple St.
Isler, Nathaniel C...521 Spring St.
Reeder, Henry H.....140 High St.
Weems, Mallory P...404 Spring St.
Wilber, Harold R....437 Spring St.

Regan, George L.....Sellersburg
Sturgis, D. G.....Sellersburg
Vandervert, Arthur C..Sellersburg

CLAY COUNTY

Maurer, J. Frank.....Brazil
Maurer, Robert M.....Brazil
Palm, John M.....Brazil
Shattuck, John C.....Brazil
Sourwine, Clint C.....Brazil
Weaver, Timothy M. (H)...Brazil
Webster, Robert K.....Brazil
Wood, Opal L.....Brazil
Bond, Walter C.....Clay City
Glosson, Jack R.....Clay City
Ward, Harry H. (H).....Coalmont

CLINTON COUNTY

Waits, Chester L.....Colfax

Frankfort

Applegate, A. E...51 E. Walnut St.
Beardsley, Frank A.
51 S. Jackson St.
Beardsley, John..51 S. Jackson St.
Burroughs, Carroll A.
59 S. Main St.
Carrel, Francis E.
207½ N. Jackson St.
Chittick, A. G....206 E. Walnut St.
Compton, Charles B.
51 S. Jackson St.
Dykhuizen, Theodore A.
59 S. Main St.
Erdel, Milton W.....59 S. Main St.
Hammersley, Geo. K.
361 E. Clinton St.
Hedgcock, Robert A.
205 E. Clinton St.
Holmes, Claude, Sr...9½ W. Clinton
Jones, William W.
9½ W. Clinton St.
Robison, Claude A...59 S. Main St.
Stout, Harry T., Jr.
361 E. Clinton St.
Van Kirk, John A.
204 W. Washington St.
Van Kirk, Paul P.
204 W. Washington St.
Work, Bruce A..47½ S. Jackson St.
Carlyle, Ivan E.....Michigantown
Combs, Nelson B.....Mulberry
Kent, John A.....Mulberry
Grove, Robert H.....Rossville
Ketcham, John S.....Rossville
Michael, Isaacs E.
Mayo Clinic, Rochester, Minn.

CRAWFORD COUNTY

Gobbel, Novy E.....English
Nolan, Robert .....English
Benz, Jesse .....Marengo
Johnson, Jess J. (H)....Milltown
Lynch, Otis R.....Marengo
King, Everett A.
Elizabeth City, N. C.

DAVIESS-MARTIN COUNTIES

Rohrer, James R.....Elnora
Chattin, Robert E.....Loogootee
Lett, Emory B.....Loogootee
Strange, John W.....Loogootee
McCracken, Jacob O...Montgomery
Sears, Don .....Odon
Coleman, H. G.....Odon
Gilkison, John S.....Shoals
Maschmeyer, Robert H.....Shoals
Blazey, Arthur G.....Washington
Burress, Bert O.....Washington
Chattin, Vance J.....Washington
Denny, E. Rankin.....Washington
Farris, John J.....Washington
Fox, C. Philip.....Washington
Lindsay, Hamlin B.....Washington
Lloyd, Claude A.....Washington
McKittrick, Jack .....Washington
McNaughton, L. M.....Washington
Norton, Horace .....Washington
Rang, Arthur A.....Washington
Rang, Robert H.....Washington
Schafer, Wm. C.....Washington
Schroeder, Henry ....Washington
Shields, Harry A.....Washington
Smoot, Emory B.....Washington

DEARBORN-OHIO COUNTIES

Baker, Leslie M.....Aurora
Duncan, William F. (H)....Aurora
Jackson, John K.....Aurora
Olcott, Charles W.....Aurora
Stewart, Omer H.....Aurora
Treon, James F.....Aurora
McNeely, Matthew J.....Dillsboro
Elliott, John C.....Guilford
Fagaly, William J...Lawrenceburg
Houston, Fred D....Lawrenceburg
Pfeifer, James M....Lawrenceburg
Streck, Francis A....Lawrenceburg
Vail, George A.....Lawrenceburg
Fessler, Gordon S.....Rising Sun
Manley, Charles N.....Rising Sun

DECATUR COUNTY

Tremain, Milton A. (H)...Adams
Acher, Robert P.....Greensburg
Blemker, Russell H.....Greensburg
Callaghan, Winship C..Greensburg
Dickson, Dale D.....Greensburg
McKee, Harley S.....Greensburg
Miller, James C.....Greensburg
Morrison, James T.....Greensburg
Mullikin, Clarence W...Greensburg
Overpeck, Charles ....Greensburg
Sallee, William T.....Greensburg
Harkcom, Harry E.....St. Paul
Porter, Edward A.....Westport

DEKALB COUNTY

Thill, Leonard S.....Ashley
Covell, Harry M.....Auburn
Geisinger, Lewis N. (H)..Auburn
Hines, Archie V.....Auburn
Hippensteel, Harland V....Auburn
Nugen, Harold .....Auburn
Rogers, Evered E.....Auburn
Sanders, Jesse A.....Auburn
Souder, Bonnell M.....Auburn
Wills, Max .....Auburn
Hathaway, Clayton B.....Butler
Weirich, Charles I.....Butler
Jinnings, Loren E.....Garrett
Kantzer, Floyd B.....Garrett
Nason, Robert A.....Garrett
Reynolds, D. Monroe.....Garrett
Reynolds, Russell P.....Garrett
Coleman, Floyd B.....Waterloo
Showalter, John P.....Waterloo
Mettler, Don C.
Lowry Field, Denver, Colo.
Van Nest, Willard A.
New Smyrna Beach, Fla.

DELAWARE-BLACKFORD COUNTIES

Brown, Stewart D.....Albany
Puterbaugh, Karl E.....Albany
Hurley, John R.....Daleville
Tucker, Oral A.....Daleville
Ames, George F. (H).....Eaton
Ko, Richard .....Eaton
Downard, Leland F.....Gaston
Langsdon, Fred R.....Gaston
Dando, G. H. (H)...Hartford City
Dodds, Jas. U.....Hartford City
Hoffman, Herman ...Hartford City
Jackson, Dean B.....Hartford City
Owsley, C. E. M.....Hartford City
Owsley, Guy A.....Hartford City
Parks, George.....Hartford City
Weldy, Bryce P.....Hartford City
Werry, Leslie E.....Hartford City
Burns, Paul E.....Montpelier
Douglas, William T.....Montpelier
Taylor, James A. (H)..Montpelier

Muncie

Adams, W. B.....Ball Mem. Hosp.
Alvey, C. R.
402 W. Washington St.
Ball, Clay A.....303 W. Adams
Ballard, John E...Ball Mem. Hosp.
Bibler, Henry E.....311 W. Adams
Botkin, C. G.....508 W. Jackson
Botkin, Thos.....1625½ University
Bowles, J. H.....317 E. Adams St.
Brown, Leland G.
104 West. Res. Bldg.
Brown, Thomas M.
104 West. Res. Bldg.
Butterfield, R. M...315 W. Jackson
Clauser, E. H. M...315 S. Jefferson
Clevenger, J. H....424 W. Jackson
Cole, R. E.....203 West. Res. Bldg.
Covalt, W. E..305 West. Res. Bldg.
Cure, E. T.....105 West. Res. Bldg.
Davis, Edgar C.....107 Plaza Bldg.
Deutsch, Wm....309 Johnson Bldg.
Dunn, F. W.....118 S. Franklin
Egbert, Clarence H....2010 S. Vine
Fitch, Ray T.....1708 W. Jackson
Funk, John W.....217 W. Charles
Galliher, M. J.....115 S. Liberty
Garling, L. C...420 W. Washington
Gill, Thos. A.....808 W. Jackson
Greiber, M. F...420 W. Washington
Gustafson, Milton..808 W. Jackson
Hall, Orville A....514 Wysor Bldg.
Hayes, T. R.....210 S. High
Henderson, R. A.....806 W. Main
High, Ralph L..420 W. Washington
Hill, Howard E.....402 W. Jackson
Hill, Robert E.....215 W. Jackson
Hostetter, Irwin S...115 N. Cherry
Hurley, Anson G....110 N. Cherry
Imhof, Jos. D..206 West. Res. Bldg.
Kammer, G. C..420 W. Washington
Kammer, W. F..420 W. Washington
Kemper, A. T. (H)..112 W. Adams
Kern, C. B. (H).715 E. Washington
Kirshman, F. E.....211 S. High
Kuder, Howard V.
420 W. Washington
LaDuron, J. F.....517 S. Liberty
Mahuron, Boyd L..Ball Mem. Hosp.
Mason, L. R.....401 W. Jackson
McClellan, John B...613 W. Charles
McClintock, James A.
316 W. Adams
McCoy, George E..417 Wysor Bldg.
McDowell, Fletcher W.
315 S. Jefferson
McMichael, R. M....324 W. Adams
Molloy, W. J. (H)..310 W. Jackson
Montgomery, Lall G.
Ball Memorial Hospital
Moore, Thos. C.....110 N. Cherry
Moore, Wm. C.....110 N. Cherry
Morris, Jean W..247 Johnson Bldg.
Owens, R. R...406 West. Res. Bldg.
Owens, T. R...202 West. Res. Bldg.
Peacock, Robert C. .....Muncie
Quick, Wm. J...314 E. Washington
Rettig, Arthur C...314 W. Jackson
Rivers, Glynn A....806 W. Jackson
Schulhof, M. G.....418 W. Wash.
Silvers, Jas. M. (H).220 W. Adams
Smith, Jas. S.....501 Kirby
Spurgeon, O. E..310 E. Washington
Stocking, B. W....Ball Mem. Hosp.
Stogsdill, Willis..Ball Memo. Hosp.
Tindal, E. F. (H).214 Wysor Bldg.
Tomlin, Hugh M.
420 W. Washington
Turner, Robt. D.....217 S. Liberty
Venis, K. N.....108 N. Liberty
Vlaskamp, E. M.....401 W. Main
Williams, J. H.....306 E. Jackson
Wood, Amelia T.....2004 Petty Rd.
Young, G. S.....316 W. Jackson

Craigmile, Thomas K....Oakville
Moss, Mavor J.....Yorktown
Rose, Stuart.....416 Grosvenor,
Montreal 28, Canada
Wasley, Malcolm T.
8938 S. Gunn Ave.
Whittier, Calif.

DUBOIS COUNTY

Backer, Henry G.....Ferdinand
Bretz, John M.....Huntingburg
Lukemeyer, L. C. (H)
Huntingburg
Steinkamp, E. F.....Huntingburg
Stork, Harvey K.....Huntingburg
Williams, F. P.....Huntingburg
Blessinger, Paul J.....Jasper
Casper, Joseph F.....Jasper
Greenburg, Rolland .....Jasper
Heck, Martin C.....Jasper
Held, George A.....Jasper
Klamer, Charles H.....Jasper
Lukemeyer, St. John.....Jasper
Salb, Leo A.....Jasper
Wagner, Arthur L.....Jasper

ELKHART COUNTY

Horswell, Richard G.....Bristol
Neidballa, Edward G.....Bristol

ELKHART COUNTY
(Continued)

Elkhart

Arlook, Theo. D...912 W. Franklin
Bender, Robt. L....411 S. Third
Billings, Elmer R..115 S. Third St.
Birge, Jackson P..414 N. Second St.
Bloom, Geo. R.....506 S. Second
Bolin, Robt. S.....209 S. Second
Bowdoin, Geo. E....515 S. Second
Compton, W. A.....2225 Greenleaf
Conklin, R. L.....1906 E. Jackson
Cormican, H. L.....316 S. Fourth
Crandall, L. A..Ames Laboratories
DeDario, L. M.....123 W. Marion
Dewey, Fred N. (H)..127 N. Fifth
Elliott, Lloyd A.....405 S. Second
Fleming, C. F.....121 W. Marion
Fleming, Justus M..123 W. Marion
Hull, Arthur W.....506 S. Second
Hunn, Maro F.....415 S. Second
Kintner, B. E....132 Monger Bldg.
Kistner, A. W.....123 W. Marion
Kistner, John W..337 Equity Bldg.
Koehler, Elmer G....Monger Bldg.
Logan, Richard S...Monger Bldg.
Lundt, Milo O.....519 S. Second
Markel, Ivan J....215 W. Franklin
McKee, H. N. (H)
319 Monger Bldg.
Mendez, Carlos.....116 W. Marion
Miller, H. A., Jr...314 W. Jackson
Miller, Samuel T.....506 S. Second
Mininger, E. P....413 W. Franklin
Mishkin, Irving.....209 S. Second
Norris, Allen A. (H)
208 W. Marion
Paff, Wm. A.....515 S. Second
Paine, Geo. E.....419 Modrell
Pancost, R. H..160 Riverview Ave.
Pancost, V. K.....415 S. Second
Patrick, Glenn B....427 S. Second
Possolt, Thos. R...208 Equity Bldg.
Rohr, Joseph H....1425 E. Jackson
Rupe, Lloyd O.....Equity Bldg.
Schlosser, H. C.....116 W. Marion
Sears, M. M. (H)..304 Equity Bldg.
Spray, Page E.....405 S. Second
Stauffer, W. A....214 Equity Bldg.
Stout, R. B....1501 Greenleaf Blvd.
Stubbins, Wm. M.....412 S. Second
Swank, L. F.....315 Equity Bldg.
Swihart, H. R.....417 N. 2nd St.
Swihart, L. F.....214 W. Marion
Todd, David D.
2001 E. Jackson Blvd.
Wilson, O. E.....217 N. Main
Work, Jas. A., Jr.....412 S. Second
Yoder, C. Richard
427 S. Second St.

Goshen

Amstutz, H. C.....521 S. Main
Bartholomew, M. L....107 S. Fifth
Bender, C. K....115 E. Washington
Eby, Ida L.....131 S. Main
Freeman, F. M.....109 W. Wash.
Hostetler, C. M.....304 E. Lincoln
Kelly, Wm. R.....210 N. Main
Kinzie, M. Dale.....Shoots Bldg.
Martin, Floyd S.....127 E. Lincoln
Miller, M. E.....Spohn Bldg.
Simmons, L. H.....208 E. Lincoln
Turner, John P.....Shoots Bldg.
VanderBogart, Harry E.
31 Shoots Bldg.
Westfall, Geo. S.....214 E. Lincoln
Yoder, Albert C.....113 S. Fifth
Young, Ralph H....113 E. Madison

Farver, Moses A. (H)..Middlebury
Norris, Ernest B.....Middlebury
Teters, Melvin S.....Middlebury
Chandler, Leon H.....Millersburg
McClelland, Harry N..Millersburg
Fleetwood, R. A.....Nappanee
Kendall, Forest M.....Nappanee
Price, Douglas W.....Nappanee
Price, Melvin D. (H)....Nappanee
Slabaugh, Jancy S. (H)..Nappanee
De Fries, John.....New Paris
Stuckman, E. D. (H)...New Paris
Amick, Charles L.....Wakarusa
Hannah, Jack W.....Wakarusa
Elliott, Thomas A..4577 Utopia Dr.,
New Orleans 20, La.

FAYETTE-FRANKLIN COUNTIES

Foreman, Walter A.....Brookville
Glaser, Robert E.....Brookville
Hoeger, Hobart R.....Brookville
Peters, Elmer .....Brookville
Seal, Perry F.....Brookville
Smith, Herbert N.....Brookville

Connersville

Ashworth, Lewis N.....716 Grand
Cavitt, Robert F.....930 Central
Dale, Maxwell H.....818 Grand
Ellis, Geo. M., Jr.....108 E. Tenth
Entner, Charles L.....117 E. Sixth
Fruth, Rodney B.....634 Eastern
Fruth, Virgil J.....634 Eastern
Gordin, Stanley B.....R. D. 3
Gordin, Stanton E. (H)....R. D. 4
Gregg, Albert F.....124 E. Sixth
Kemp, William A...122 W. Seventh
Lockhart, Jack M.....520 Eastern
Mountain, Francis B...930 Central
Neukamp, Frank H.
American Central Mfg. Co.
Smelser, Herman W....823 Central
Watterson, Gerald T.
1910 Virginia Ave.

Daley, Edward H.....Oldenburg

FLOYD COUNTY

Engleman, Harry K...Georgetown

New Albany

Allen, Frederick K.
1207 E. Spring St.
Baker, Avey M.....811 E. Spring
Baxter, Jas. W.....1201 E. Spring
Baxter, Saml. M....1201 E. Spring
Briscoe, C. E.....1413 E. Spring
Brown, Kenneth H...410 E. Spring
Byrn, Howard W...416 Elsby Bldg.
Cannon, Daniel H..216 Elsby Bldg.
Davis, Parvin M.....601 E. Spring
Day, George H.....1252 Vincennes
Edwards, William F.
Floyd County Bank Bldg.
Garner, Wm. H.....919 E. Spring
Geller, Samuel .....Owensville
Gentile, John P.....1313 E. Spring
Hauss, A. P.....212 Elsby Bldg.
Hess, Paul P.
Floyd Co. Bank Bldg.
Higgins, John R.
Old Vincennes Rd.
LaFollette, Robt. E.....500 Spring
McCullough, J. Y.....624 E. Spring
Murphy, Edgar W.....1824 State
Pace, Jerome V....Silvercrest San.
Paris, John M.....602 E. Spring
Pierce, Gene S.....R. R. 21
Pierson, Percy R.
203 Liberty State Bank Bldg.
Polhemus, G. I.....1610 E. Spring
Robertson, A. N.....820 E. Spring
Shacklett, Henry B. (H)
117 E. Spring St.
Sloan, Herbert.....1207 E. Spring
Streepey, J. I.....1102 E. Spring
Tyler, Frank T.....420 Vincennes
Voyles, Harry E...216 Elsby Bldg.
Weaver, Wm. W....1104 E. Spring
Witt, William R..908 E. Spring St.
Wohlfeld, Gerald.Silvercrest San.
Wolfe, Nelson.....908 E. Spring

FOUNTAIN-WARREN COUNTIES

Fisher, John E.....Attica
Freed, Carl A.....Attica
Freed, James C.....Attica
Maris, Lee J.....Attica
Aldridge, James W.....Covington
Johnson, Earl E.....Covington
Stephens, Lowell R.....Covington
Suzuki, T. T.....Covington
Priebe, Fred H.....Hillsboro
Smith, Byron J.....Kingman
Himebaugh, G. J.....Veedersburg
McCord, Carl B.....Veedersburg
Rusk, Hubert M.....Wallace
Nelson, Carl A.....West Lebanon
Crain, James W.....Williamsport
Schmiedicke, P. H....Williamsport

FULTON COUNTY

Herrick, Charles L.....Akron
Miller, Virgil .....Akron
Dielman, Franklin C.....Fulton
Kelsey, Lawrence E.....Kewanna
Kraning, Kenneth K.....Kewanna
Glackman, John C.....Rochester
Herendeen, Elbie V.....Rochester
King, Milo O.....Rochester
Richardson, Chas. L.....Rochester
Rowe, Howard H.....Rochester
Stinson, Arthur E.....Rochester
Stinson, Dean K.....Rochester

GIBSON COUNTY

Geick, Raymond G.....Fort Branch
Hollis, Walter.....Fort Branch
Marchand, Austin F.....Haubstadt
Marchand, Edwin V.....Haubstadt
Pettijean, Harold G.....Haubstadt
Arthur, Hamilton M. (H) Hazelton
Ropp, Eldon R.....Oakland City
Turner, Maurice.....Oakland City
Wood, Russell W.....Oakland City
Montgomery, James R...Owensville
Alexander, Harry H.....Princeton
Brazelton, O. T.....Princeton
Carpentier, Harry F.....Princeton

GIBSON COUNTY

(Continued)

Folck, John K. . . . . Princeton
Graves, Orville M. . . . . Princeton
Hollingsworth, M. P. (H) . Princeton
McCarty, Virgil . . . . . Princeton
McElroy, Robert S. . . . . Princeton
Miller, Charles A. (H) . . . Princeton
Morris, W. F. (H) . . . . . Princeton
Peck, James F. . . . . Princeton
Rhodes, Amos H. . . . . Princeton
Strickland, Karl S. . . . . Princeton
Weitzel, Roland . . . . . Princeton

GRANT COUNTY

Holliday, L. D. . . . . Fairmount
King, Dale S. . . . . Fairmount
Seale, Joseph P. . . . . Fairmount
Garrison, Leon J. . . . . Gas City
Koontz, William A. . . . . Gas City
Baskett, Russell J. . . . . Jonesboro

Marion

Abell, Chas. F.
321 Marion Natl. Bk. Bldg.
Alderfer, Henry
516 Marion Natl. Bank Bldg.
Ayres, Wendell W. . . 302 Glass Blk.
Bloom, Asa W. . . . . 724 W. Third
Boyer, Grace M. . 313 Iroquois Bldg.
Braunlin, Robert F.
718 Marion Nat. Bank Bldg.
Braunlin, William H.
718 Marion Nat. Bank Bldg.
Brown, Robert M.
522 Marion Nat. Bank Bldg.
Burge, A. D. (H)
204 Odd Fellows Bldg.
Currie, Robert W. . . Veterans Hosp.
Daniels, Erle O.
708 Marion Nat. Bank Bldg.
Daniels, Geo. R. . . . . 324 Glass Blk.
Davis, Joseph B.
516 Marion Nat. Bank Bldg.
Davis, Merrill S.
516 Marion Nat. Bank Bldg.
Davis, Richard
516 Marion Natl. Bank Bldg.
Diamond, Leo L.
413 Marion Nat. Bank Bldg.
Dick, Fred . . . . . Marion Gen. Hosp.
Eshleman, L. H. (H) . 2927 S. Wash.
Fisher, Henry . . . . . 1502 S. Wash.
Ganz, Max . . . . . 930 S. Adams
Ginsberg, S. T. . . . . Veterans Hosp.
Huff, Asher D. . . . . 310 Glass Blk.
Hummel, Russel M.
317 Marion Nat. Bank Bldg.
Lavengood, R. W. . . . 511 Glass Blk.
Leiter, Forrest C. . . 506 Glass Block
Long, Max R. . . . . 803 S. Boots
McIlwain, Eleanor E. . . . 107 E. 31st
McIlwain, Robt. E. . . . . 107 E. 31st
Miller, H. Allison . . . 321 Glass Blk.
Powell, J. Paxton . . . 309 Glass Blk.
Powell, Nettie B. (H) . . 615 Whites
Renbarger, L. L. . . . 1531 W. Second
Rhorer, John G. . . . . 201 S. D St.
Sandy, Wm. A. . . . . Veterans Hosp.
Simmons, Fredk. H.
520 Whites Ave.
Skomp, C. E. . . . . Marion Gen. Hosp.
Warren, Carroll B. . . 408 Glass Blk.
Weinberg, Samuel. . . 318 Glass Blk.
Williams, C. L. . . . . Veterans Hosp.
Young, Robt. G. . . . . 2927 S. Wash.
King, Peter C. . . . . Swayzee
Taylor, Everett C. . . . . Upland
Rifner, E. S. . . . . Van Buren
List, Harold E. . . . . Naval Air Sta., Glenview, Ill.
Williams, C. L.
Veterans Hosp., Lexington, Ky.

GREENE COUNTY

Graf, Jerome A. . . . . Bloomfield
Mount, Mathias S. . . . . Bloomfield
Turner, Harold B. . . . . Bloomfield
Turner, Jack J. . . . . Bloomfield
Van Sandt, Frank A. . . . Bloomfield
Porter, Carl M. . . . . Jasonville
Rotman, Harry G. . . . . Jasonville
Rotman, Sam I. . . . . Jasonville
Bailey, Edwin B. . . . . Linton
Broshears, Kenneth . . . . . Linton
Craft, William F. . . . . Linton
Porter, George C. . . . . Linton
Raney, Ben B. . . . . Linton
Tomak, Milton E. . . . . Linton
Woner, John W. . . . . Linton
Manzie, Michael W. . . . . Lyons
Simons, James (H) . . . . . Lyons
Hamilton, M. Luther . . . . Newberry
Fender, Asa H. . . . . Worthington
Moses, George E. . . . . Worthington
Moses, Robert E. . . . . Worthington

HAMILTON COUNTY

Hicks, Joseph (H) . . . . . Arcadia
Rodenbeck, Frank . . . . . Arcadia
McDaniel, Franklin P. . . . . Atlanta
Campbell, Sam W. . . . . Carmel
Donahue, Claude M. . . . . Carmel
Havens, Oscar . . . . . Cicero
Tomlinson, C. H. (H) . . . . . Cicero
Ambrose, Jesse C. . . . . Noblesville
Harris, Robert F. . . . . Noblesville
Hash, John S. . . . . Noblesville
Hooke, Samuel W. . . . . Noblesville
Kraft, Haldon C. . . . . Noblesville
Shanks, Ray . . . . . Noblesville
Shonk, Harold W. . . . . Noblesville
Southard, Carl B. . . . . Noblesville
Thayer, Jos. O. . . R.R. 1, Noblesville
Griffith, James W. . . . . Sheridan
Newby, Alonzo C. . . . . Sheridan
Newby, Eugene . . . . . Sheridan
Reck, John L. . . . . Sheridan
Young, Edward M. (H) . . . Sheridan
Connoy, Andrew F. . . . . Westfield
Connoy, Leo F. . . . . Westfield

HANCOCK COUNTY

Ferrell, Jesse E. . . . . Fortville
Ferrell, Mars B. . . . . Fortville
Manifold, Harold M. . . . . Fortville
Navin, Hugh K. . . . . Fortville
Allen, Joseph L. (H) . . . . Greenfield
Endicott, Wayne . . . . . Greenfield
Gibbs, Charles M. (H) . . . Greenfield
Gill, Dee D. . . . . Greenfield
Heller, Oscar S. (H) . . . . Greenfield
Kinneman, Robert E. . . . . Greenfield
Rariden, Lawrence B. . . . Greenfield
Vingus, Bronie . . . . . Greenfield
Woods, James R., Jr. . . . . Greenfield
Larrabee, William H. (H)
New Palestine
Pierson, Thos. A. . . . New Palestine
Kuhn, Robert W. . . . . Wilkinson
Titus, Charles R. (H) . . . Wilkinson

HARRISON COUNTY

Amy, William E. . . . . Corydon
Blessinger, Louis H. . . . . Corydon
Brockman, Wilfred . . . . . Corydon
Dillman, Carl E. . . . . Corydon
Baker, Guy D. . . . . Crandall
Mathys, Alfred . . . . . Mauckport
Glenn, Lafayette . . . . . Ramsey

HENDRICKS COUNTY

Foltz, Lloyd E. . . . . Brownsburg
Scudder, Arthur N. . . . Brownsburg
Tyner, Harlan H. . . . . Clayton
Ellett, John, Jr. . . . . Coatesville
Frantz, Mount E. . . . . Danville
Gibbs, Joseph W. . . . . Danville
Koch, Elmer L. . . . . Danville
Price, Ernest H. . . . . Danville
Terry, Lloyd . . . . . Danville
Ellis, Lyman H. . . . . Lizton
Wiseheart, O. H. (H) . North Salem
Scamahorn, Malcolm O. . . Pittsboro
Scamahorn, Oscar T. . . . Pittsboro
Aiken, Milo M. . . . . Plainfield
Cohen, Irving . . . . . Plainfield
Johnston, Alan . . . . . Plainfield
Stafford, James C. . . . . Plainfield
Stafford, William C. . . . . Plainfield

HENRY COUNTY

Call, Earle B. . . . . Knightstown
Dreyer, Ralph W. . . . Knightstown
Walker, Jack . . . . . Knightstown
Scheetz, Marion R. . . . . Lewisville
Dragoo, Farrol . . . . . Middletown
Hammer, Jay W. . . . . Middletown
Stauffer, George E. . . . . Mooreland
Marshall, Lloyd C. . . . . Mt. Summit

New Castle

Amos, Robert L. . . . . 1219½ Race St.
Bitler, Clyde C. . . . . 1319 Church
Blaize, Joshua A.
Ind. Village for Epileptics
Bledsoe, James G. . . . . 319 S. 14th
Burnett, Arthur B. . 310 Burr Bldg.
Canaday, Clifford E. (H)
1411 Church
Craig, Alexander F. . R. F. D. No. 2
Fisher, John E. . . . . 409 Burr Bldg.
Harrison, B. L. . 118 Jennings Bldg.
Foster, Ray T. . . . . Chrysler Corp.
Harrison, B. L. . 118 Jennings Bldg.
Heilman, William C. . . 1319 Church
Hill, Kenneth G. . . . . 1319 Church
Iterman, George E. . . . 1319 Church
Kennedy, Walter U. . . . . 214 S. 14th
Life, Homer L. . . . . 101 S. 11th St.
McDonald, Frank C. . . . 106 N. Main
McElroy, James S. . . . . 1319 Church
Poston, Clement L.
209 Bradbury Bldg.
Smith, Robert A. . 1229 Lincoln Ave.
Stout, Walter M. . . . . 1319 Church
Thorne, Charles E. . . . . 200 N. 12th
Tully, John A. . . . . 502 S. Main
Van Nuys, W. C.
Ind. Village for Epileptics
Wiggins, Dulania S. (H)
1222½ Race
Wiggins, George . . . . . 1222½ Race

Wilson, Ralph (H) . . . . . Shirley
Robertson, William S. . . . Spiceland

HOWARD COUNTY

Denton, Larkin D.....Greentown
Shoup, Homer B.....Greentown

Kokomo

Adams, Charles J.
618 Armstrong Landon Bldg.
Alward, John H.
401 W. Walnut St.
Boughman, Joe D.
322 Armstrong-Landon Bldg.
Bowers, C. C.....210 W. Mulberry
Bowers, Garvey B 210 W. Mulberry
Bowers, John A...210 W. Mulberry
Bruegge, Theodore J.
630 Armstrong-Landon Bldg.
Clarke, Elton R.....521 N. Main
Conley, Thomas M.
520 Union Bank Bldg.
Craig, Reuben A.
608 Armstrong-Landon Bldg.
Crawford, Theo. R.
416 W. Sycamore
Cuthbert, Fredk. S 211 E. Jefferson
Earl, Max M.....409 W. Taylor
Ferry, P. W...406 Union Bk. Bldg.
Good, Richard P.
308 Armstrong-Landon Bldg.
Halfast, Richd. W..214 E. Mulberry
Hutto, William H.
408 Armstrong-Landon Bldg.
Jewell, George M.
508 Armstrong-Landon Bldg.
Knepple, LaMarr R. (H)
325½ N. Main
Kratzer, Eugene F..320 W. Walnut
Lung, Bruce D 410 Union Bk. Bldg.
McIndoo, Ralph E...304 W. Walnut
Meiner, Joseph A.....911 S. Main
Morford, Guy 1017 W. Superior St.
Morrison, William R.
504 Union Bank Bldg.
Murray, Ernest C..207 E. Mulberry
Paris, Durward W.
614 Armstrong-Landon Bldg.
Phares, Robt. W...905 W. Mulberry
Ramey, John W.....107½ S. Union
Rhorer, Herbt. M..210 W. Mulberry
Rudicel, Max..1700 S. Washington
Schuler, Russell P....200½ N. Main
Schwartz, Frederick C.
518 Armstrong-Landon Bldg.
Scott, Russell F....Union Bk. Bldg.
Shenk, Earl M.....208½ N. Main
Smith, Gloster J..105½ E. Sycamore
Sorenson, Raymond
522 Armstrong-Landon Bldg.
Spangler, Jesse S....215 E. Taylor

Evans, Robert M.....Russiaville

HUNTINGTON COUNTY

Huntington

Brubaker, Harold S 42 W. Park Dr.
Casey, Stanley M....408 E. Market
Clunie, Wm. A.....502 N. Jefferson
Cope, Stanton E..1022 N. Jefferson
Erehart, Mark G....232 W. Market
Eviston, John B.....34 E. Wash.
Galbreath, Russell S...16 W. Wash.
Gray, Paul M.....340 E. Market
Grayston, Fred W. (H)
708 N. Jefferson
Grayston, W. S.....303 E. Market
James, Thomas, Jr...48 E. Franklin
Johnston, Robt. G....339 E. Market
Marks, Howard H.....248 W. Park
Meiser, Robt. D...612 N. Jefferson
Mitman, Floyd B.....210 W. Park
Nie, Grover M.....220 W. Park Dr.
Omstead, T. W..244 E. Washington
Ware, James R.....48 E. Franklin

Woods, Halden C.....Markle
Bigelow, Oliver P.....Roanoke
Bennett, J. B.....Warren
Black, C. S.....Warren
Bonifield, Harold F.....Warren
Smith, Lucian .....Warren

JACKSON COUNTY

Cummings, David J...Brownstown
Gillespie, Garland R...Brownstown
Shields, Jack E.....Brownstown
Adair, William K.....Crothersville
Bard, Frank B.....Crothersville
Conner, Thos. E. (H)....Freetown
Black, Joe M.....Seymour
Day, William D. C.....Seymour
Elsner, Lawrence W.....Seymour
Gillespie, Charles E.....Seymour
Graessle, Harold P.....Seymour
Kamman, Geo. H. (H)....Seymour
Martin, Guy .....Seymour
Miller, Harold E.....Seymour
Osterman, Louis H.....Seymour
Ripley, John W.....Seymour
Shortridge, Wilbur H.....Seymour
Wiethoff, Clifford A.....Seymour

JASPER-NEWTON COUNTIES

Pippenger, Wayne G.....Brook
Ockermann, Kenneth R...DeMotte
Openshaw, James F.....Goodland
Smith, Marsh H.....Goodland
Mathews, Wilbur C.....Kentland
VanKirk, George H.....Kentland
Yegerlehner, Roscoe S....Kentland
Donovan, Joseph W.....Morocco
Larrison, Glenn D.....Morocco
Schubert, Justin C.....Morocco
Schantz, Richard .....Remington
Sink, Frank G.....Remington
Beaver, Ernest .....Rensselaer
English, Harry E.....Rensselaer
Johnson, Cecil E.....Rensselaer
Kresler, Leon .....Rensselaer
O'Neill, Martin .....Rensselaer
Gwin, Merle D...2111 Regatta Ave.,
Miami Beach, Fla.

JAY COUNTY

Garber, Edwin C.....Dunkirk
Hall, Emory H.....Dunkirk
Heller, Nelson L. R.....Dunkirk
Shroyer, Herbert .....Dunkirk
Hiestand, Harley J.....Pennville
Badders, Ara C.....Portland
Cring, George V.....Portland
Dulin, Basil .....Portland
Engle, John M.....Portland
Fitzpatrick, James .....Portland
Hammond, Stanley M.....Portland
Keeling, Forrest E.....Portland
Lyon, Florence .....Portland
Moran, Mark M.....Portland
Morrison, George G.....Portland
Schwartz, Wm. D. (H)...Portland
Spahr, Donald E.....Portland
Steffy, Ralph .....Portland
Hanna, Duke .....Redkey
Lansford, John .....Redkey
Kidder, John J. (H)....Salamonia

JEFFERSON COUNTY

Robertson, David W.....Deputy
Henning, Carl .....Hanover

Madison

Beetem, Luther F.....425 W. Main
Childs, A. G. W. (H)..412 E. Main
Childs, Wallace E.....420 Elm
Denny, Fred C...Odd Fellows Bldg.
Hamilton, Guy W. (H)
Clifty Hotel
Jolly, Lewis E.....Madison Clinic
Kemp, M. W. Madison State Hosp.
May, George A.....426 E. Main
Modisett, Jackson W.
Madison Clinic
Modisett, Marcella S.
Madison Clinic
Petway, Allen P.....426 E. Main
Prenatt, Francis
Madison State Hospital
Sharman, E. J.....610 E. Second
Shuck, Wm. A...Odd Fellows Bldg.
Totten, Evan C. (H)
415 W. 2nd St.
Turner, Anna L.....104 E. Third
Turner, Oscar A.....104 E. Third
Whitsitt, Schuyler A. (H)
718 W. Main
Zink, Robert O.....Madison Clinic

JENNINGS COUNTY

Robertson, David W. (H)..Deputy
Calli, Louis .....North Vernon
Green, John H.....North Vernon
Grossman, Wm. L....North Vernon
Matthews, Dennis W.North Vernon
Stemm, Wm. H. (H).North Vernon
Thayer, Benet W....North Vernon

JOHNSON COUNTY

Manuel, Donald .....Edinburg
Deppe, Charles F.....Franklin
Eaton, Lyman D.....Franklin
Ferrara, Joseph F.....Franklin
Jones, Charles A.....Franklin
Murphy, George M.....Franklin
Murphy, Harry E.....Franklin
Portteus, Walter L.....Franklin
Province, Oran A.....Franklin
Province, William D.....Franklin
Records, Arthur W.....Franklin
Wilson, Russell C.....Franklin
Barnes, Helen Beall....Greenwood
Brown, George E.....Greenwood
Sheek, Kenneth I.....Greenwood
Tiley, George A.....Greenwood
Woodcock, Charles E....Greenwood
Machledt, John H.....Whiteland

KNOX COUNTY

Byrne, Robert J.....Bicknell
Donham, William L.....Bicknell
Fox, Richard H. (H).....Bicknell
Meade, Walter W.....Bicknell
Wilson, Guy H.....Bicknell
Scudder, John A.....Edwardsport
Raper, Geo. T.....Freelandville
Hodges, William A.....Oaktown
Springstun, George H....Oaktown
Pahmeier, John W.....Sandborn

Vincennes

Anderson, Richard M.
301 LaPlante Bldg.
Arbogast, Paul B.....915 Main
Bailey, W. A. (H)....516 Busseron
Beckes, Ellsworth W..603 Busseron
Beckes, N. E. (H)...414 Broadway
Boyd, Claudius L....114 N. Fourth
Chattin, Herbert O.....729 Main
Coffel, Melvin H.
424 LaPlante Bldg.
Cullison, Charles W.
1237 N. 9th St.
Curtner, Myron L.....222 N. Sixth
Edwards, Edward T., Jr.
1045 Washington Ave.
Ewing, Nathaniel D....14 N. Third
Fox, Maurice S.....616 Shelby St.
Green, Carl L.....1004 Main
Hoffman, Doris.....324 Vigo
Humphreys, Joe E....217 N. Third
Johnson, Morris H. C....9 N. Fifth
McCormick, Hubert D.
325 LaPlante Bldg.
McDowell, Mordecai M.
211 American Bank Bldg.
McMahan, Virgil C.
410 LaPlante Bldg.
Meyer, Raymond C..Hillcrest Hosp.
Moore, Robert G.....21 N. Third
Nance, William K.....324 Vigo
Reilly, James F.....418½ Main
Richards, D. H. (H)
215 American Nat. Bk. Bldg.
Schulze, William
223 American Bank Bldg.
Shaffer, Kenneth L.
404 LaPlante Bldg.
Smith, Ralph O.....12 S. Fourth
Smith, Saml. J..301 LaPlante Bldg.
Spencer, Frederic
421 LaPlante Bldg.
Sullenger, A. A....214 S. Fifth St.
Welch, Norbert M.
410 LaPlante Bldg.

KOSCIUSKO COUNTY

McIlroy, Richard J.....Claypool
Thomas, Charles E. (H)..Leesburg
Urschel, Dan .....Mentone
Hursey, Virgil G.....Milford
Stalter, Gaylord W....N. Webster
Herring, George N.....Pierceton
Schuldt, T. S.....Pierceton
King, James R.....Silver Lake
Clark, Fred .....Syracuse
Craig, Robert A.....Syracuse
Fosbrink, E. L.....Syracuse
Haymond, George M.....Warsaw
Hillery, John L.....Warsaw
Leininger, Hilbert A. P...Warsaw
Richer, Orville H.....Warsaw
Schlemmer, George H.....Warsaw
Thomas, Everett W.....Warsaw

LAGRANGE COUNTY

Wade, Alfred A.....Howe
Benedict, Charles D.....LaGrange
Flannigan, Harley F.....LaGrange
Schulz, Clarence H.....LaGrange
Weir, Dale .....LaGrange
Robertson, Wm. .....Shipshewana
Hildebrand, William O.....Topeka
Lehman, Kenneth M.....Topeka

LAKE COUNTY

Bolin, John T.....Cedar Lake
King, Robert W.....Cedar Lake

Crown Point

Becker, Philip H.
Lake County T. B. Sanitarium
Birdzell, John P. ....124 N. Main
Carroll, Mary E.....124 N. Main
Gray, Daniel E.....235 S. Main
Horst, William N.....138 S. Main
Iddings, John W.....124 N. Main
Klaus, J. M.....224 S. Court
Merchant, Raymond..269 Maxwell
Monroe, F. Bruce.....Crown Point
Seyler, Anna G.
Lake County T. B. Sanitarium
Steele, Everett B.....124 N. Main
Troutwine, William..224 S. Court
Weis, William D. (H).Court House

Adler, Edmund R.....Dyer
Dassel, Paul M.....Dyer

East Chicago

Arnold, M. F.
4614 Indianapolis Blvd.
Barron, Elmer A..3406 Guthrie St.
Beam, Vernon B.....Du Pont Co.
Beilke, Clifford A...815 W. Chicago
Benchick, Frank A.
4712 Magoun Ave.
Benedek, Tibor....3406 Guthrie St.
Bonaventura, Angelo P.
3701 Main St.
Boyd, Chas. S...4739 Melville Ave.
Boys, Fay F...722 W. Chicago Ave.
Brauer, Abraham A..3528 Main St.
Braun, Benjamin D.
St. Catherine's Hospital
Broomes, Edw. L.....3924 Deal St.
Callahan, Richard H..3502 Main St.
Campagna, Ettro A...3406 Guthrie
Carleton, Edward H.
Inland Steel Co.
Cole, Arthur V....3406 Guthrie St.
Cotter, Edward R.
723 W. Chicago Ave.
Dainko, Alfred J.
823 W. Chicago Ave.
Ernst, H. C...720 W. Chicago Ave.
Fleischer, Jacob C....3406 Guthrie
Gardiner, H. Glenn...3210 Watling
Govorchin, Alexander
724 W. Chicago Ave.
Grosso, William G.
722 W. Chicago Ave.
Gustaitis, John W.
815 W. Chicago Ave.
Hamilton, Robert C.
2602 E. 140th Place
Hayes, Jesse D.....4742 Melville
Irish, Wilbur J.
806 W. Chicago Ave.
Johns, David R.
724 W. Chicago Ave.
Kaplan, Benjamin B..3738 Main St.
Komoroske, John E.
723 E. Chicago Ave.
Kopanko, Bernard F.
823 W. Chicago Ave.
Levin, Eli .....3700 Main St.
McGuire, Desmond F.
3429 Michigan Ave.
Marks, Ora L..815 W. Chicago Ave.
Mervis, Frank H.
3414 Michigan Ave.
Nakadate, Katsumi J.
815 W. Chicago Ave.
Niblick, James S.....3406 Guthrie
Nicosia, John B.....3701 Main St.
O'Connor, James J...3701 Main St.
Payne, Arthur C...2020 Broadway
Petronella, Samuel J.
4614 Indianapolis Blvd.
Ramker, Daniel T.
3406 Guthrie Ave.
Shapiro, Joseph .....3700 Main St.
Shulruff, H. I.....3701 Main St.
Smith, Louis D.
St. Catherine's Hosp.
Teegarden, Joseph A., Jr.
3336 Michigan Ave.
Teegarden, Joseph A.
3336 Michigan Ave.
Trepagnier, Francis B.
3616 Main St.
Vore, Hugh A...4231 Magoun Ave.
Zallen, Stanley G.
720 W. Chicago Ave.
Zivich, John M.....3701 Main St.

Gary

Almquist, Carl O.....504 Broadway
Baitinger, Herbert M.
504 Broadway
Balkin, Ruth B...Methodist Hosp.
Behn, Walter M.....738 Broadway
Bendler, Carl H.....738 Broadway
Bills, Robert N.....504 Broadway
Boardman, Carl ....504 Broadway
Borak, Walter J..6151 W. 25th Ave.
Brady, Samuel G. ...765 Broadway
Brandman, Harry...504 Broadway
Brink, Calvin C.....504 Broadway
Brown, David B. ....504 Broadway
Brown, Leo R.....3855 Broadway
Bullard, Mattie J...524 Garfield St.
Burcham, James B...738 Broadway
Carbone, Joseph A...504 Broadway
Carmody, Raymond F.
504 Broadway
Chevigny, Julius J...504 Broadway
Cooper, Leo K.....670 Hayes St.
Cotterman, Vernon L.
3811 Washington St.
Crossland, Steward H.
Methodist Hospital
Daneileski, L. J.....738 Broadway
Darling, Dorothy..1600 W. 6th Ave.
Davis, Neal, Box 928, Ogden Dunes
DeLong, Charles A. (H)
574 Monroe St.
Dian, August J. ....729 Broadway
Dian, Julia .....729 Broadway
Dierolf, Edward J..504 Broadway
Donchess, Joseph C..215 Broadway
Doty, James R.....504 Broadway
Duncan, John S....2165 W. 11th St.

LAKE COUNTY

(Gary—Continued)

Elliott, Ralph A.....504 Broadway
English, Hubert M...673 Broadway
Galante, Vincent J..Mercy Hospital
Gannon, G. W.....602 Broadway
Goldberg, Harold B..515 Broadway
Goldstone, Adolph ..757 Broadway
Goldstone, Joseph ..757 Broadway
Goldstone, S. R.....757 Broadway
Gorton, Mary L.....400 Broadway
Grant, Benjamin ..1706 Broadway
Gregoline, A. F.....729 Broadway
Gutierrez, F. A.....504 Broadway
Harris, Donald N.....4813 Madison
Hedrick, James T...1901 Broadway
Hodurski, Zigfield ..4319 Broadway
Holmes, George W...504 Broadway
Jannasch, Maurice C.738 Broadway
Jeffress, Jessie E...325 W. 6th Ave.
Johnson, Lonnie B.
123 W. 21st St.
Kahan, Harry L.....738 Broadway
Kendrick, Frank J...504 Broadway
Knoy, Norris .....Gary
Kobrin, Meyer W....729 Broadway
Kolettis, George J...860 Broadway
Kopcha, Joseph E....504 Broadway
Korn, Jerome M.....742 Broadway
Kron, R. Vincent
3538 Central, East Gary
Lebioda, Henry S...8 W. Ridge Rd.
Lorenty, Thaddeus B.
738 Broadway
Lovell, Martin H...1606 Broadway
Lutz, Georgianna....504 Broadway
McMichael, F. J. .....504 Broadway
Majsterek, Stanley L.
1902 W. 11th Ave.
Marcus, Morris C....738 Broadway
Mather, J. W.....3543 Central,
East Gary
May, Richard M.....583 Broadway
Minczewski, Richard C.
504 Broadway
Molengraft, Cornelius J.
527 Broadway
Moore, E. Gregory .1901 Broadway
Moore, Edwin G....1606 Broadway
Morris, Hyman ....17 W. 8th Ave.
Moswin, Jack A.....790 Broadway
Nelson, Walfred R..559 S. Lake St.
Nesbit, Otis B. (H) .444 Jackson St.
Neuwelt, Frank ....504 Broadway
Ornelas, Jos. P.....607 Broadway
Palmer, Russell H.
2006 W. 4th Place
Parker, Harry C.....673 Broadway
Parratt, Louis W...100 E. 7th Ave.
Purcell, Richard J..Mercy Hospital
Puryear, James O..1606 Broadway
Reynolds, James S...504 Broadway
Robinson, Walter K..504 Broadway
Rosenbloom, Philip J.
504 Broadway
Rubin, Simon S. ....504 Broadway
Ryan, Hubert J. ....504 Broadway
Sagel, Jacob .....504 Broadway
Sala, Joseph J. .....504 Broadway
Sala, Walter R. .....504 Broadway
Schaible, Ernest L...738 Broadway
Senese, Thos. J.....504 Broadway
Shellhouse, Michael
3811 Washington St.
Skeen, Earl D. .....504 Broadway
Slama, George D...3624 Buchanan
Spellman, Frank W....564 S. Lake
Spivack, Mary ....3855 Broadway
Sponder, Joseph ...1512 Broadway
Stimson, H. R.....504 Broadway
Stoycoff, Christo M..844 Broadway
Templin, David B....504 Broadway
Thomas, Daniel D...738 Broadway
Thomas, Gerald J...504 Broadway
Trinosky, Donald L..504 Broadway
Turgi, Robert W....673 Broadway
Verplank, Grover L..527 Broadway
Vye, James P.....607 Broadway
Washington, G. Kenneth
1606 Broadway
Weiskopf, Henry S...504 Broadway
Wharton, Russell O..673 Broadway
White, W. J. (H)....790 Broadway
Wicks, Orlando C. (H)
560 Van Buren
Williams, Alexander S.
504 W. 25th St.
Wimmer, Robert N.....9 W. 6th St.
Yarrington, Charles W.
607 Broadway
Yocum, Paul S. .....738 Broadway
Yocum, Wm. S. .....583 Broadway
Young, George M...3776 Broadway

Hazinski, R. T. .....Griffith
Lundeberg, Ralph A.....Griffith
Malmstone, F. A.....Griffith
Siekierski, Joseph M.....Griffith

Hammond

Allegretti, Michael L.
5404 Hohman Ave.
Arbeiter, Herbert I.
5231 Hohman Ave.
Arrowsmith, James L.
5231 Hohman Ave.
Beconovich, Robt.
6010 Columbia Ave.
Bethea, Dennis ....1021 Fields St.
Brown, Stanley L.
6550 Hohman Ave.
Carlo, Joseph F.
5305 Hohman Ave.
Chidlaw, B. W...5141 Hohman Ave.
Clancy, James F.
5231 Hohman Ave.
Cook, George M.
5231 Hohman Ave.
Davis, Alice L...5116 Hohman Ave.
Detrick, Herbert W.
5231 Hohman Ave.
Eggers, Ernest L.
5141 Hohman Ave.
Eggers, Henry W.
5231 Hohman Ave.
Egnatz, Nicholas...522½ State S.t
Elledge, Ray....5231 Hohman Ave.
Fischer, Burnell
7403 Van Buren Ave.
Friedman, Isadore E.
5248 Hohman Ave.
Gevirtz, Milton B.
5246 Hohman Ave.
Groman, Herman C..137 Rimbach
Hack, Edmund C.
5217 Hohman Ave.
Hansen, Arthur H.
5252 Hohman Ave.
Hickman, A. L..5248 Hohman Ave.
Hofmann, Andrew
5135 Hohman Ave.
Hopkins, J. R...5217 Hohman Ave.
Howard, William H.
5231 Hohman Ave.
Husted, Robert G.
5248 Hohman Ave.
Jones, Eli S....5231 Hohman Ave.
Justin, Jerome W.
5231 Hohman Ave.
Kolanko, Leon A.
5435½ Hohman Ave.
Koransky, David S.
5231 Hohman Ave.
Kretsch, R. W. ....5231 Hohman
Kuhn, Hedwig S...112 Rimbach St.
Kuhn, Hugh A.....112 Rimbach St.
Larrabee, James F.
5245 Hohman Ave.
Lazo, Vicente R.
5446 Calumet Ave.
McLean, James S....522½ State St.
McVey, Clarence A.
5231 Hohman Ave.
Marcus, Emanuel
5252 Hohman Ave.
Marks, Salvo .....409 Yale Bldg.
Matthews, Charles B. (H)
5252 Hohman Ave.
Modjeski, Joseph R.
5451½ Hohman Ave.
Modjeski, Raymond J.
5231 Hohman Ave.
Morrison, Lindsey (H)
109 Rimbach St.
Murphy, Joseph F., Jr.
139 Rimbach St.
Musacchio, Frederick A.
330 City Hall
Neal, Leonard W.
5252 Hohman Ave.
Nelson, Richard B.
5618 Calumet Ave.
Nichols, William E. (H)
15 Warren St.
Nodinger, Louis.....540 165th St.
Panares, Solomon V.
5434 Hohman Ave.
Paul, William Thomas F.
5434 Hohman Ave.
Peck, Edward A..422 Conkey St.
Peiffer, Geraldine M.
5231 Hohman Ave.
Pilot, Jean .....5231 Hohman Ave.
Premuda, F. F..6727 Kennedy Ave.
Rawlins, Carolyn M.
422 Conkey St.
Remich, Antone C..137 Rimbach St.
Rendel, Donald T.
5231 Hohman Ave.
Rhind, A. W....5145 Hohman Ave.
Rosevear, Henry S.
5231 Hohman Ave.
Row, Perrie Q...5231 Hohman Ave.
Rudolph, Franklin G.
5231 Hohman Ave.
Schlesinger, Daniel J.
6010 Columbia
Schlesinger, Jacob
6010 Columbia Ave.
Seglin, Robbert V.
5305 Hohman Ave.
Shanklin, E. M. (H)
5141 Hohman Ave.
Skrentny, Stanley
5231 Hohman Ave.
Sosson, Edward .....112 Rimbach
Stasick, Murray...60 Douglas St.
Stern, Samuel L.
5231 Hohman Ave.
Tilka, Edward ..6719 Calumet St.
Wood, Frederic H. 5960 Hyslop Pl.

LAKE COUNTY

(Hammond—Continued)

Zeman, Theodore C.
112 W. Rimbach St.

Acos, James C.
2805 Highway Ave., Highland
Markey, Richard J. P.
2805 Highway Ave., Highland
Sroka, Stanley J.
8606 Kennedy Ave., Highland
Dupes, Lowell E. ..... Hobart
Friedrich, Louis M. (H) .... Hobart
Markle, Joseph G. ..... Hobart
Pike, Warren H. ..... Hobart
Reed, John ..... Hobart
Storer, W. R. ..... Lowell
Combs, Loyal ..... Lowell
Mirro, John A. ..... Lowell
Campbell, Guy C. ..... Munster
Teplinsky, Louis L. ..... Munster

Whiting

Bechtol, Lavon D.
1902 Indianapolis Blvd.
Ferry, John
1902 Indianapolis Blvd.
Frankowski, Clementine E.
1907 New York Ave.
Greisen, Jack G.
1902 Indianapolis Blvd.
Jones, Clifford M.
1902 Indianapolis Blvd.
Kudele, Louis T. .... 1321 119th St.
LaFollette, Forrest R.
1900 Indianapolis Blvd.
Marshall, Millard R.
1900 Indianapolis Blvd.
McCarthy, Jeremiah A.
1341 E. 119th St.
Rudser, Donald H.
1902 Indianapolis Blvd.
Silvian, Harry A. .... 1400 119th St.
Smith, Theodore J.
1902 Indianapolis Blvd.
Stecy, Peter
1902 Indianapolis Blvd.
Thegze, G. A. ..... 1344 119th St.
Troy, Jack M.
1900 Indianapolis Blvd.
Walker, Adolph P.
1648 Calumet Ave.
Weinberg, B. A. .... 1348 119th St.

Kobrak, H. G. ..... 950 E. 59th St., Chicago 31, Ill.
Lewis, Marvin A.
7839 Phillips Ave., Chicago, Ill.
Richter, Samuel
Charity Hosp., New Orleans, La.
Rubin, Milton R.
Veterans Hosp., Fresno, Calif.
Schliecker, Alexander G. (H)
Troy, Mo.
Tyrrell, Thomas C.
704 Wentworth Ave., Calumet City, Ill.
Vracin, Daniel J.
10727 S. Paramount Blvd., Downey, Calif.

LAPORTE COUNTY

Oak, David, Jr. ..... Hanna
Oak, David D. ..... LaCrosse

LaPorte

Carter, Fred S. .... 402 E. Jefferson
Cartwright, Jack D.
806 Madison St.
Elshout, Clem H. .. 1004 Indiana Ave.
Fargher, Robert A.
811 Jefferson Ave.
Farnsworth, Samuel A.
1002 Michigan Ave.
Fischer, Carlton N.
1001 Maple Ave.
Jones, John C. ..... 801 Madison
Jones, Robert B.
808 Michigan Avenue
Kelly, Jon N. .... 704 Jefferson Ave.
Kelsey, Robert M. .. 702 Maple Ave.
Kepler, Robert W. .. 708 Harrison St.
Kistler, James J. .... 911 Maple Ave.
Larson, G. O. .... 809 Jefferson St.
Linn, Elbert E. .... 809 Jefferson St.
Martin, William B.
812 Michigan Ave.
Morgan, Samuel P.
810 Michigan Ave.
Muhleman, C. E. .. 901 Indiana Ave.
Przednowek, Adolph C.
909 Madison St.
Richter, John C. .. 808 Michigan Ave.
Ross, Wilbur W. ..... P. O. Box 102
Simon, Arthur R. .. 806 Maple Ave.
Von Asch, George .. 912 Monroe St.
Wilcox, Robert F. .. 808 Maple Ave.

Michigan City

Armstrong, Thomas D.
120 W. Ninth St.
Baker, Warren .. 427 Warren Bldg.
Bankoff, Milton L. .... 123 E. 5th St.
Bernoske, Daniel G. .... 731 Pine St.
Brooks, Harry L. ..... 123 E. 5th St.
Burris, Floyd L. ..... 731 Spring St.
Carlson, Norman R. .. 229 E. 5th St.
Donovan, Stephen J.
916 Washington St.
Fargher, Francis M.
723 Franklin St.
Fein, Harry S. ..... 125 E. 5th St.
Feerer, Donald .. 117 W. Seventh St.
Flaherty, Walter T.
1016 Washington St.
Gardner, Melvin D.
801 Washington St.
Gardner, Russell A.
801 Washington St.
Gilmore, Robert W.
304 Warren Bldg.
Gilmore, Russell A.
301 Warren Bldg.
Grotts, Bruce F.
801 Washington St.
Henderson, N. C.
622½ Franklin St.
Hillenbrand, Charles
128 W. Tenth St.
Jones, King Solomon
328½ Franklin St.
Kemp, John T. ..... 122 E. 7th St.
Kerrigan, Robert L.
916 Washington St.
Kling, Victor F. .. 507 Warren Bldg.
Kohrman, Benjamin M.
123 E. Fifth St.
Kress, James W. .... 125 E. 5th St.
Krieger, George M.
701 Washington St.
Kubik, Francis J. .... 201 E. 8th St.
Lava, Irving M. ..... 125 E. 5th St.
Meyer, Milo G. .. 801 Washington St.
Molenda, Robert V.
801 Washington St.
Piazza, Leonard F.
404 Warren Bldg.
Pilecki, Peter J. .... 125 E. 5th St.
Plank, C. Robert ... 732 E. Pine St.
Reed, Ann M. ..... 123 E. Fifth St.
Reed, Nelle ..... 501 Pine St.
Robrock, Lawrence M.
315 Warren Bldg.
Spinning, A. L. (H)
130 Superior St.
Straus, David C. .... 123 E. Fifth St.
Walters, William H. .. Warren Bldg.
Weeks, Patrick H. ..... Box 41

Weinstock, Adolph .. Rolling Prairie
Moosey, Louis ..... Union Mills
Hetman, Mitchell J. ..... Westville
Benz, Owen ..... Wanatah

LAWRENCE COUNTY

Bedford

Allen, L. Howard
305 Citizens Nat. Bank Bldg.
Austin, Richard P.
209 Citizens Nat. Bank Bldg.
Benham, L. E. .. Citizens Bank Bldg.
Bridwell, Edgar ..... 1317 L St.
Dusard, Joseph C.
304 Citizens Nat. Bank Bldg.
Edmonds, Kendrick .. 1303 15th St.
Emery, Charles B. .... 1027 15th St.
Fountaine, Thomas J.
200 Citizens Nat. Bank Bldg.
Hammel, Howard T.
Citizens Nat. Bank Bldg.
Kerr, Donald M. ..... 1317 L St.
Martin, Frank D. ..... 1501 I St.
Meyer, Orlando L. ..... 1317 L St.
Newland, Arthur E. .. 1112 15th St.
Pearson, John R. (H)
Citizens Nat. Bank Bldg.
Ragsdale, Harrison C.
200 Citizens Nat. Bank Bldg.
Robertson, Moorman O.
400 Citizens Nat. Bank Bldg.
Scherschel, John P. ..... 1711 H St.
Smallwood, Robert B.
204 Citizens Nat. Bank Bldg.
Stone, Charles E.
Von Ritz Theatre Bldg.
Wohlfeld, Julius B. .... 1124 16th St.
Woolery, Richard
207 Citizens Nat. Bank Bldg.
Wynne, Roland E.
301 Citizens Nat. Bank Bldg.

Hamilton, James R. ..... Mitchell
Oswalt, James Telfer ..... Mitchell
Strickland, William B. .... Mitchell
Dollens, Claude ..... Oolitic

MADISON COUNTY

Carpenter, John L. ..... Alexandria
Gaunt, Everett W. ..... Alexandria
Overpeck, George H. .... Alexandria
Shafer, Richard H. ..... Alexandria

Anderson

Aagesen, Walter J.
615 Citizens Bank Bldg.
Armington, Charles L.
657 Anderson Bank Bldg.

MADISON COUNTY

(Anderson—Continued)

Armington, John C.
657 Anderson Bk. Bldg.
Armington, Robert L.
318 Citizens Bank Bldg.
Austin, Charles E.
530 Citizens Bank Bldg.
Austin, Maynard A. (H)
238 W. 12th St.
Ayres, Kenneth D.
2210 Meridian St.
Baughn, William L.
1635 W. 12th St.
Benoit, Merrill P.....Delco Remy
Blassaras, Chris....2005 Broadway
Brauchla, Carl H...117 W. 17th St.
Brown, James M.
609 Anderson Bldg.
Brock, Earl E.....931 Meridian St.
Buckles, David L..St. John's Hosp.
Collins, Albert W. (H)
1834 Broadway
Conrad, Ernest M. (H)
2124 Meridian
Dixon, Rex W.....934 W. 8th St.
Doenges, James L.
631 Citizens Bank Bldg.
Drake, John C.
604 Anderson Bank Bldg.
Ellis, Seth W.....335 W. 5th St.
Elsten, Aubrey W.
704 Anderson Bank Bldg.
Erehart, Archie D.
714 Anderson Bank Bldg.
Fischer, Warren E.
St. John's Hospital
Gante, Henry W.
1110 N. Meridian St.
Guthrie, Francis C.
412 Anderson Bank Bldg.
Hart, William D.
515 Citizens Bank Bldg.
Hensler, Benton M..12 W. 29th St.
Jarrett, Paul E.
315 Citizens Bank Bldg.
Jones, Albert T.
712 Anderson Bank Bldg.
Jones, Horace E.
1110 Meridian St.
Kelly, Wendell C.....704 E. 8th St.
King, Joseph W.
1110 N. Meridian St.
Kopp, Otis A..1110 N. Meridian St.
Lamey, James L.
447 Citizens Bank Bldg.
Lamey, Paul T.
423 Citizens Bank Bldg.
Larmore, Joseph L.
712 Anderson Bank Bldg.
Larmore, Sarah M.....R. R. 8
Litzenberger, Sam W.
622 Citizens Bank Bldg.
Long, Paul L.
710 Anderson Bank Bldg.
McDonald, Vergil G.
1110 Meridian St.
Meister, Doris
403 Citizens Bank Bldg.
Metcalf, George B.
931 Meridian St.
Miley, Weir M....717 Madison St.
Neale, Alfred
234 Citizens Bank Bldg.
Nelson, Paul L....330 West 7th St.
Nesbit, Leonard L.
415 Citizens Bank Bldg.
Patterson, William K.
St. John's Hospital
Polhemus, Warren C.
1803 Pearl St.
Quickel, Daniel S. (H)
5 Griffith Bldg.
Reed, Roger R.
412 Anderson Bank Bldg.
Rosenbaum, Lloyd E.
647 Citizens Bank Bldg.
Ross, Guy E.
661 Citizens Bank Bldg.
Rozelle, Clarence V.
615 Citizens Bank Bldg.
Sharp, William L.
449 Citizens Bank Bldg.
Stamper, Joseph H...R. R. 7, Bx. 47
Swan, Richard C.....Delco Remy
Tracy, Julius R.....738 W. 8th St.
Webb, Harry.....105 W. 11th St.
Welsh, John B.
709 Anderson Bk. Bldg.
Wilder, Gordon B.
612 Anderson Bank Bldg.
Wilkinson, Roger L...4 E. 38th St.
Williams, Francis ....1132 Central
Williams, Robert H.
1132 Central Ave.
Willson, Canby L.
2003 Meridian St.
Wright, Cecil S.
523 Citizens Bank Bldg.
York, Arthur F.
602 Citizens Bank Bldg.
Zierer, R. O.....931 Meridian

Elwood

Cullipher, Jeremiah E. (H)
903 Main St.
Drake, M. C.....1201 Main St.
Hanson, Martin F.
1102 S. Anderson St.
Hoppenrath, Wesley M.
1300 Main St.
Hoppenrath, William H. (H)
1300 Main St.
Laudeman, Walter A.
1515 North A St.
Ploughe, Monroe L. (H)
517 S. Anderson St.
Ploughe, Ralph R..517 S. Anderson
Scea, Wallace.....1300 Main St.

Bishop, Harry A.....Frankton
Maxon, Roy V.....Lapel
Rinne, John I. .....Lapel
Williams, Robert D....Markleville
McLaughlin, Calvin P....Pendleton
Sisson, Helen M. .....Pendleton
Irwin, Seth .....Summitville
VanNess, William C...Summitville
McVaugh, Charles C.
4503 N. Winchester, Chicago, Ill.

MARION COUNTY

Huffman, Albert D.....Acton
Berger, Morley
902 Main St., Beech Grove
Kim, Young D.
136 N. 17th St., Beech Grove
Ramage, Walter F.
244 S. First St., Beech Grove
Rhea, James C.
801 Main St., Beech Grove
Hade, F. L. .....Bridgeport
Zerfas, Leon G. ....R. R. 1. Camby
Fosgate, Harold L.....Cumberland
Garrison, James L. ...Cumberland

Indianapolis

A

Abreu, Benedict E.
1200 Madison (6)
Adkins, Harold C...409 E. 30th (5)
Adkins, Onan C.
3635 Watson Rd. (5)
Albertson, Frank P.
5304 W. Washington (21)
Aldrich, Harry D.
501 Hume Mansur Bldg. (4)
Aldrich, Howard
4316 E. Washington (1)
Alexander, Ezra D.
617 Indiana, No. 304 (2)
Allen, Robert K.
3309½ Broadway (5)
Alvis, Edmond O.
320 Hume Mansur Bldg. (4)
Anderson, Wendell C.
1330 W. Michigan (7)
Appel, Richard H.
603 Hume Mansur Bldg. (4)
Arbogast, J. L.
I.U. Med. Center (7)
Arbuckle, Russell
508 Doctors' Bldg. (4)
Arbuckle, Wm. E.....1156 Lee (21)
Arnold, Aaron L.
607 E. Maple Rd. (5)
Arnold, Robert D. 3419 E. 10th (1)
Aronson, Sidney S.
618 Hume Mansur Bldg. (4)

B

Bachmann, Arnold J.
207 W. 34th (8)
Bahr, Max A. (H)
Central State Hospital (22)
Bakemeier, Otto H.
5503 E. Washington (19)
Balch, James F.
709 Hume Mansur Bldg. (4)
Ball, Joseph E.....5039 E. 10th (1)
Banister, Revel F..2958 Central (5)
Banks, Horace M.
Methodist Hosp. (7)
Barnum, Edwin N.
General Hosp. (7)
Barrett, D. C.
1330 W. Michigan St. (7)
Barry, M. Joseph, Sr.
508-509 Doctors' Bldg. (4)
Bartley, Max D.
803 Hume Mansur Bldg. (4)
Batman, Gordon W.
723 Hume Mansur Bldg. (4)
Battersby, J. Stanley
I. U. Medical Center (7)
Batties, Paul A.
308 Walker Bldg. (2)
Bauer, Thomas B.
1015 Hume Mansur Bldg. (4)
Baum, Harry
VA Regional Office (4)
Baumeister, Herbert E.
3375 Forest Manor (18)
Beach, Robert R...2630 E. 10th (1)
Bean, Joseph S...General Hosp. (7)
Beasley, Thomas J.
112 Berkley Rd. 8)
Beaver, Howard W.
11 E. Raymond (25)
Beck, Evart M.
633 E. Maple Rd. (5)
Beckman, Henry F.
5245 Washington Blvd. (20)

MARION COUNTY

(Indianapolis—Continued)

Beeler, John W.
712 Hume Mansur Bldg. (4)
Beeler, Raymond C.
712 Hume Mansur Bldg. (4)
Berger, Henry I.
6060 Gladden Dr. (20)
Berman, Edward J.
General Hosp. (7)
Berman, Jacob K.
807 Hume Mansur Bldg. (4)
Berton, William M.
Methodist Hosp. (7)
Beverland, Malon E.
3036 E. Washington (1)
Bibler, Lester D.
811 Underwriters Bldg. (4)
Bigler, Frederick W.
General Hosp. (7)
Bird, Charles R. (H)
301 Hume Mansur Bldg. (4)
Blatt, A. Ebner
3209 N. Meridian (8)
Bloemker, Edward F.
2729 Shelby (3)
Boaz, John J. . . 302 K.ofP.Bldg. (4)
Boggs, Eugene F.
2901 N. Meridian St. (8)
Bohner, Caryle B.
822 Hume Mansur Bldg. (4)
Boling, Grover C., Jr.
Methodist Hosp. (7)
Bond, George S.
1221 N. Delaware St. (2)
Booher, Norman R.
447 E. Maple Rd. (5)
Booher, Olga Bonke
447 E. Maple Rd. (5)
Booth, Boynton H.
910 Hume Mansur Bldg. (4)
Bowers, Don L
711 Underwriters Bldg. (4)
Bowman, George W.
1140 E. Market (2)
Boyer, Edward B.
725 Hume Mansur Bldg. (4)
Boyer, Floyd A. . . 442 N. Drexel (1)
Brady, Thomas A.
818 Hume Mansur Bldg. (4)
Brayton, John R.
704 Underwriters Bldg. (4)
Brayton, Lee . . . 3342 N. Illinois (8)
Bridges, William L.
I.U. Medical Center (7)
Brincko, John Methodist Hosp. (7)
Brodie, Donald W.
817 C. of C. Bldg. (4)
Brown, Archie E.
1220 S. Belmont (21)
Brown, David E.
520 Hume Mansur Bldg. (4)
Brown, DeWitt W.
920 Hume Mansur Bldg. (4)
Brown, Edward A. (H)
201 Fountain Sq. Th. Bldg. (3)
Brown, Frances T.
2126 N. Talbot (2)
Brown, Wendell E.
802 C. of C. Bldg. (4)
Browning, James S.
3209 N. Meridian (8)
Browning, William M.
3740 Central (5)
Breutsch, Walter L.
Central State Hospital (22)
Buck, Charles E.
I. U. Medical Center (7)
Bunde, Carl A.
Pitman-Moore Co. (6)
Burdette, Harold F.
3202 N. Meridian (8)
Burghard, Rolla D.
3760 N. Sherman Dr. (18)
Burney, Leroy E.
1330 W. Michigan (7)
Butler, John O. General Hosp. (7)
Butler, Robert M.
3608½ E. 10th (1)
Buttz, Rose J. P. . . . 112 E. 13th (2)

C

Cahal, Ernest . . . . . 2614 Shelby (3)
Cahn, Hugo M. . . . . 506 E. 30th (5)
Caldwell, Marilyn Riley Hosp. (7)
Call, Herbert F.
321 Hume Mansur Bldg. (4)
Campbell, John A.
I. U. School of Medicine (7)
Canaday, James W. (H)
1229 Prospect (3)
Caplin, Irvin . . 2033 N. Harding (2)
Caplin, Samuel S. . . . 111 E. 30th (5)
Carlson, Charles E.
Allison Div. G.M.C.
Carson, Wayne
1011 Hume Mansur Bldg. (4)
Carter, James C.
502 Hume Mansur Bldg. (4)
Carter, Oren E. . . . . 668 E. 38th (5)
Caseley, Donald
I.U. Med. Center (7)
Cayley, Frank J.
Central State Hospital (22)
Chattin, Wm. R. . General Hosp. (7)
Chen, Ko Kuei . . Eli Lilly & Co. (6)
Chroniak, Walter . . 4625 E. 10th (1)
Clark, Cecil P.
922 Hume Mansur Bldg. (4)
Clark, Cyrus J. . . 6325 Guilford (20)
Clark, Lawson J.
3736 N. Delaware (5)
Clevinger, William G.
1610 Auburn St. (24)
Close, W. Donald
809 Hume Mansur Bldg. (4)
Coble, Ralph R.
3311 N. Meridian (8)
Cohn, Alvin C. . Methodist Hosp. (7)
Collins, Hubert L.
985 N. Arlington (19)
Collins, James N.
712 Hume Mansur Bldg. (4)
Conley, Joseph L.
2443 E. Washington (1)
Conway, Chester C.
4402 E. New York (1)
Conway, Glenn . . . 1620 S. East (25)
Cook, Charles J. (H)
2405 Carrollton (5)
Copeland, Samuel J.
427 Bankers Trust Bldg. (4)
Cornacchione, Matthew
814 S. East (25)
Cortese, James V. . 435 S. East (25)
Cortese, Thomas A.
435 S. East (25)
Courtney, John W.
518 Hume Mansur Bldg. (4)
Cox, Clifford E.
R. R. 16, Box 593 (44)
Cox, Harold B.
5316 E. Washington (19)
Craft, Kenneth L.
1002 Hume Mansur Bldg. (4)
Craven, Howard T.
922 Hume Mansur Bldg.
Crawford, John A.
650 E. 34th St. (5)
Culbertson, Clyde G.
Lilly Research Lab. (6)
Cullen, Paul K.
422 Hume Mansur Bldg. (4)
Culloden, William G.
710 E. 46th (5)
Cunningham, John M.
508 Hume Mansur Bldg. (4)
Cure, Charles W.
914 Hume Mansur Bldg. (4)
Cusack, Robert
6111 College Ave. (20)
Cuthbert, Marvin
203 Hume Mansur Bldg. (4)

D

Dailey, John E. . . 56 W. 30th St. (8)
Dalton, John E.
707-708 Hume Mansur Bldg. (4)
Dalton, William W.
209 Hume Mansur Bldg. (4)
Daniel, John C.
1008 Hume Mansur Bldg. (4)
Davidson, N. Cort
3008 Clifton (23)
Davis, John A. . . . 2719 E. Mich. (1)
Davis, Sam J.
908 Hume Mansur Bldg. (4)
Deal, Eleanor H. B.
1544 Main St., Speedway (24)
Dearmin, Robert M.
3233 N. Meridian (8)
DeArmond, Murray
723 Hume Mansur Bldg. (4)
Deever, John W. . . . 4131 Shelby (3)
DeMotte, C. Bowen
808 C. of C. Bldg. (4)
Denny, Forrest L.
3351 W. 10th (22)
Denny, James W.
5504 E. Washington (19)
Des Jean, Paul A.
638 K. of P. Bldg. (4)
DeWees, Dwight L.
302 N. Bradley (1)
Dilts, Robert Louis
2521 E. 38th (18)
Dintaman, Paul G.
432 Bankers Trust Bldg. (4)
Dittmer, Thomas L.
3315 N. Gladstone (18)
Donato, Albert M. . 1521 Shelby (3)
Donner, Paul G.
Norways, 1800 E. 10th (1)
Dorman, Willis L.
5508 E. Washington (19)
Dowd, Joseph A. . 6202 College (20)
Drake, William L.
General Hosp. (7)
Dryden, Gale E. . . 5 S. Belmont (22)
Dugan, Thomas J.
2540 W. Washington (22)
Dugan, William M.
410 Hume Mansur Bldg. (4)
Dunbar, Colin V.
423-4 Hume Mansur Bldg. (4)
Dunning, Lehman M.
1561 College (2)
Dyar, Edwin W.
3202 N. Meridian (8)
Dyke, Richard W.
General Hospital (7)

MARION COUNTY
(Indianapolis—Continued)

E

Earp, Evanson B.
717 Hume Mansur Bldg. (7)
Eastman, Joseph R., Jr.
1002 Merchants Bank Bldg. (4)
Eaton, Edwin R.
3120 N. Meridian (8)
Ebert, J. Wayne...509 Lincoln (3)
Eberwein, John H.
414 E. Fall Ck. Pkwy., N. D. (5)
Eckert, Russell A.
20 Johnson Ave. (19)
Egbert, Herbert L...VA Hosp. (22)
Egbert, Roy
2601 Roosevelt Ave. (18)
Eicher, Palmer O.
3209 N. Meridian (8)
Eikenberry, Hugh W.
616 Bankers Trust Bldg. (4)
Eldridge, Gail E...1440 E. 46th (5)
Elliott, Roy H..2430 E. 38th st. (5)
Ellis, Bert E.
303 Hume Mansur Bldg. (4)
Emhardt, John T..1621 S. East (25)
Emhardt, John W. A.
709 Underwriters Bldg. (4)
Ensminger, L. A.
908 Hume Mansur Bldg. (4)
Enzor, Ora K.....4216 College (5)
Ernst, Clifford E.
General Hosp. (7)
Evans, Frederick H.
17½ W. 22nd St. (2)
Evans, Paul V...General Hosp. (7)
Everly, Ralph V...4216 College (5)

F

Failey, Robert B., Jr.
420 Hume Mansur Bldg. (4)
Farrell, Joseph T.
2807 E. Michigan (1)
Fausset, C. Basil
2901 N. Meridian St. (8)
Fisch, Charles
3120 N. Meridian St. (8)
Fisk, Frank B....1200 Madison (6)
Fitzgerald, William J.
203 Ftn. Sq. Bldg. (3)
Flanigan, Meredith B.
2920 W. 33rd (22)
Flick, John J.....1443 N. Penn. (2)
Flora, Joseph O.
4317 W. Washington (21)
Folkening, Norval C.
204 Ftn. Sq. Bldg. (3)
Foreman, Harry L...60 W. 30th (8)
Forry, Frank
I. U. Medical Center (7)
Foster, Lee N.
St. Vincent's Hosp. (7)
Fouts, Paul J.
522 Hume Mansur Bldg. (4)
Franklin, William L.
508 Hume Mansur Bldg. (4)
Frazin, Bernard
Billings VA Hospital
Ft. Benj. Harrison (16)
Fromhold, Willis A.
611 Bankers Trust Bldg. (4)
Frost, John W.
740 S. Alabama (6)
Fry, Robert D.
612 Hume Mansur Bldg. (4)
Fullerton, Robert L..3665 N. Ill. (8)
Funkhouser, Arthur G.
702 Underwriters Bldg. (4)
Funkhouser, Elmer
702 Underwriters Bldg. (4)
Furgason, Paul C.
1008 Hume Mansur Bldg. (4)
Furniss, Sumner A. (H)
120 E. Market St.
c/o Ind. Natl. Bank

G

Gabe, William E.
612 Hume Mansur Bldg. (4)
Gaddy, Euclid T.
2602 W. Washington (22)
Gallup, Palmer R.
601 Inland Bldg. (4)
Gambill, William D.
1019 Hume Mansur Bldg. (4)
Gammieri, Robert L.
3326 Clifton (23)
Garber, J. Neill
806 Hume Mansur Bldg. (4)
Garceau, George J.
508 Hume Mansur Bldg. (4)
Gard, Daniel A..1156 Lee St. (21)
Gardiner, Sprague H.
314 Hume Mansur Bldg. (4)
Gardner, Buckman
St. Vincent's Hospital (7)
Garfield, Martin D.
3705 College (5)
Garner, William (H)
2911 E. 10th (1)
Garner, W. Stanley
2911 E. 10th (1)
Garrett, John D. (H)
510 Doctors Bldg. (4)
Garrett, Robert A.
I. U. Medical Center (7)
Gaskill, Herbert S.
I. U. Medical Center (7)
Gastineau, Frank M.
407 Hume Mansur Bldg. (4)
Gatch, W. D.
605 Hume Mansur Bldg. (4)
Geider, Roy A...1443 Prospect (3)
George, Charles L..507 E. 34th (5)
Gibson, Maxine
5744 Broadway Terrace (20)
Gick, Herman H.
2705 E. Michigan (1)
Gifford, Fred E.
710 Hume Mansur Bldg. (4)
Gillespie, Charles F.
3209 N. Meridian (8)
Gillespie, Jacob E.
523 Hume Mansur Bldg. (4)
Givner, David
Billings VA Hospital,
Ft. Benj. Harrison (16)
Glass, Robert L.
608 Hume Mansur Bldg. (4)
Glendening, John L.
132 Insurance Bldg. (4)
Goldman, Samuel.1266 Oliver (21)
Gosman, James H.
2901 N. Meridian (8)
Gotlib, Milton H.
St. Vincent's Hosp. (7)
Graf, John P.
I. U. Medical Center (7)
Graves, John W...4734 E. 10th (1)
Green, Myron H.
1011 Hume Mansur Bldg. (4)
Green, Oscar.....Camp Atterbury
Greist, John H.
2901 N. Meridian St. (8)
Griffith, Richard S..Lilly Clinic (7)
Griffith, Ross E.....401 E. 34th (5)
Grisell, Ted L.
504 Hume Mansur Bldg. (4)
Gunderson, Shaun D.
General Hospital (7)
Gustafson, Gerald W.
314 Hume Mansur Bldg (4)
Gutelius, Charles B.
900 Underwriters Bldg. (4)

H

Habich, Carl
702 Hume Mansur Bldg. (4)
Hadden, Claude
424 Hume Mansur Bldg. (4)
Hadley, David
809 Hume Mansur Bldg. (4)
Hadley, Murray N. (H)
809 Hume Mansur Bldg. (4)
Haggard, Edmund B.
806 Board of Trade Bldg. (4)
Hahn, E. Vernon
914 Hume Mansur Bldg. (4)
Hall, Frank M.
141 S. Meridian St. (14)
Hall, Jack R...3342 N. Illinois (8)
Hallam, F. Tulley
1129 State Life Bldg. (4)
Hamer, Homer G.
1711 N. Capitol (7)
Hampshire, Donald R.
1443 N. Pennsylvania (2)
Hancock, John G.
2226 W. Michigan (22)
Hanley, Edward J., Jr.
General Hospital (7)
Hanna, Thomas A.
1462 Main St., Speedway (24)
Hansell, R. M.....7 N. Euclid (1)
Harcourt, Allan K.
812 C. of C. Bldg (4)
Harding, M. Richard
308 Hume Mansur Bldg. (4)
Harding, Myron S.
308 Hume Mansur Bldg. (4)
Hare, Earl H.....VA Hospital (22)
Hare, Laura
404 Hume Mansur Bldg. (4)
Hargan, Jack L.
Methodist Hosp. (7)
Harger, Robert W.
I. U. Medical Center (7)
Harold, Albert H.
7510 Allisonville Rd. (44)
Harold, Norris E. (H)
3545 N. Denny St. (18)
Harris, Carl B.
319 Hume Mansur Bldg. (4)
Harris, Paul N.
Eli Lilly & Co. (6)
Hasewinkel, Carroll W.
Methodist Hospital (7)
Hasler, Norman B.
I.U. Medical Center (7)
Haslinger, Clarence J.
2151 E. New York (1)
Hatfield, B. F.
802 C. of C. Bldg. (4)
Hatfield, Jack J.
802 C. of C. Bldg. (4)
Hatfield, N. W..2032 N. Rural (18)
Hawk, James H.
514 Hume Mansur Bldg. (4)
Haymond, Joseph L.
3769 College (5)

MARION COUNTY

(Indianapolis—Continued)

Hays, Everett L. Billings VA Hosp., Ft. Benj. Harrison (16)
Hedrick, Philip W. 654 E. 54th (20)
Heinz, Dorothy C. V. . . Ind. Council for Mental Hlth., Fairgrounds (5)
Henderson, F. G. Eli Lilly & Co. (6)
Hendricks, J. D. (H) 2230 N. Del. (5)
Hendricks, John W. 911 Hume Mansur Bldg. (4)
Hennessee, Philip C. 320 Hume Mansur Bldg. (4)
Henry, Russell S. 725 Hume Mansur Bldg. (4)
Hepburn, C. K. 524 Hume Mansur Bldg (4)
Hetherington, A. M. 4121 E. New York (1)
Hetherington, John A. 822 Hume Mansur Bldg. (4)
Heubi, J. E. . . 668 E. Maple Rd. (5)
Hickman, W. F. . . . 1210 Oliver (21)
Himebaugh, James R. S.
Hilldrup, Don G. 18 W. Georgia St. (4)
Himebaugh, James R. S. 513 S. Sherman Dr. (3)
Himler, James M. 809 Underwriters Bldg. (4)
Hine, U. B. . . . . 4808 E. Mich. (1)
Hines, Don C. . . Eli Lilly & Co. (6)
Hippensteel, R. R. . . 401 E. 34th (5)
Hodges, Fletcher VA Regional Office (4)
Hofmann, J. William 323 Hume Mansur Bldg. (4)
Hollingsworth, A. A. 4032 E. Wash. (1)
Holman, J. E., Jr. 3315 E. 10th (1)
Holman, Jerome E., Sr. 523 Bankers Tr. Bldg. (4)
Holmes, Claude, Jr. 6142 Nimitz Dr.
Holtzman, Paul W. General Hosp. (7)
Hood, A. A. . . . . 1413 Roache (23)
Horwitz, Thomas 423-4 Hume Mansur Bldg. (4)
Houseworth, John H. VA Hosp. (22)
Howell, Joseph D. 760 Bankers Tr. Bldg. (4)
Howell, Robert D. 900 Underwriters Bldg. (4)
Hoyt, L. H. . . . Methodist Hosp. (7)
Huber, Carl P. I.U. Med. Center (7)
Hudson, F. J. 3440 N. Meridian (8)
Hughes, William F. (H) 4025 N. Meridian St. (8)
Hull, James E. 1751 Beeler Ave. (24)
Hummons, H. L. . . 729½ N. West (2)
Hurt, Laverne B. 635 E. Kessler Blvd. (20)
Huse, William M. 805 Hume Mansur Bldg. (4)
Hynes, Roy T. 633 E. Maple Rd. (5)

I

Irwin, Glenn W., Jr. I.U. Med. Center (7)
Iske, Paul G. 1015 Hume Mansur Bldg. (4)

J

Jackson, Frederick E. 510 Doctors Bldg. (4)
Jackson, James W. 1330 W. Mich. (7)
Jackson, J. L. . . . . 3001 E. 10th (1)
Jacobs, Harry A. 3859 Washington Blvd. (5)
Jaeger, A. S. 430 Bankers Tr. Bldg. (4)
Jaquith, Orville S. (H) 261 Blue Ridge Rd. (8)
Jay, A. N. 3233 N. Meridian (8)
Jeffries, K. I. . . . . 807 Virginia (3)
Jenkins, R. E 3311 N. Meridian (8)
Jennings, Frank L. Sunnyside Sanatorium (44)
Jewett, J. H. 3120 N. Meridian (8)
Jewett, Laurence (H.) 6497 Broadway (20)
Jewett, Robert E. 1330 W. Michigan St. (7)
Jinks, C. H. . . . . 4216 College (5)
Jobes, James E. 305 Traction Term. Bldg. (4)
Jobes, Norman E. (H) 305 Traction Term. Bldg. (4)
Johantgen, Harold N. I.U. Medical Center (7)
Johnson, Thomas W. 529 Bankers Tr. Bldg. (4)
Johnson, W. F. 2121 N. Harding (2)
Johnston, Donald D. Veterans Administration
Jones, David E. 828 C. of C. Bldg. (4)
Jones, F. P. . . 4305 E. Michigan (1)
Joseph, R. M. . . . . 1615 S. East (25)

K

Kahler, M. V. . . 2338 W. Mich. (22)
Kahn, A. J. . . . 3120 N. Meridian (8)
Kahn, H. L. . . 3120 N. Meridian (8)
Kalb, E. L. . . . . 5934 E. 21st (18)
Kammen, Leo . . . 3414 Clifton (23)
Kammen, Robt. . . 3202 W. 16th (22)
Karol, Herbert J. General Hospital (7)
Kasting, Gerald E. Methodist Hospital (7)
Katterjohn, James C. 313 Hume Mansur Bldg. (4)
Kauffman, Nelson N. 2901 N. Meridian St. (8)
Kauffman, Sidney A. 226 Hume Mansur Bldg. (4)
Keenan, R. L. 615 Hume Mansur Bldg. (4)
Keever, C. H. . . . . 5214 College (20)
Keiser, Venice D. 646 Bankers Tr. Bldg. (4)
Kelley, Clement E. Methodist Hosp. (7)
Kelly, Don E. 702 Underwriters Bldg. (4)
Kelly, John F. 517 Hume Mansur Bldg. (4)
Kelly, Walter F. (H) 5503 E. Washington (19)
Kelly, W. M. . . . 5438 E. Wash. (19)
Kempf, G. F. . . . . 307 City Hall (4)
Kendrick, W. M. . . 1829 E. 46th (5)
Kennedy, Hall 2152 N. Meridian (2)
Kennedy, H. F. . . 1105 Prospect (3)
Kenoyer, Wilbur L. 2139 College Ave. (2)
Kerr, H. R. . . . . 2817 E. Wash. (1)
Ketcham, Jane M. 514 Hume Mansur Bldg. (4)
Kilgore, B. W. . . . 3133 E. 38th (18)
Kime, Edwin N. 711 Underwriters Bldg. (4)
King, William E. 811 Hume Mansur Bldg. (4)
King, W. F. (H) 1330 W. Mich. (7)
Kingsbury, John K. 5462 E. Washington (19)
Kinzel, Robert J. W. 3120 N. Meridian (8)
Kirkhoff, Paul J. 1517 N. Emerson (19)
Kirklin, Oren L. 202 Hume Mansur Bldg. (4)
Kirtley, William R. Lilly Research Lab. (6)
Kiser, Edgar F. 226 Hume Mansur Bldg. (4)
Kitterman, Harry E. 510 Hume-Mansur Bldg. (4)
Klahr, Elsworth E. General Hosp. (7)
Klain, B. V. . . . . 4157 College (5)
Kleifgen, William A. I.U. Medical Center (7)
Kneidel, J. H. 1118 W. 37th St. (8)
Knowles, C. Y. . . . . 4625 E. 10th (1)
Kohlstaedt, George W. 422 Hume Mansur Bldg. (4)
Kohlstaedt, Karl C. 422 Hume Mansur Bldg. (4) 3660 W. 16th (2))
Kohlstaedt, Kenneth G. General Hosp. (7)
Koons, Karl M. 922 Hume Mansur Bldg. (4)
Kopecky, R. R. 4131 Shelby St. (27)
Kornafel, L. H. 608 K. of P. Bldg. (4)
Kraft, Bennett 760 Bankers Tr. Bldg. (4)
Krueger, John E. I.U. Medical Center (7)
Kuntz, Herman W. 501 Hume Mansur Bldg. (4)
Kurtz, Fred B. 5520 N. Illinois St. (8)
Kurtz, P. L. . . . . 668 E. 38th (5)
Kwitny, I. J. . . 3209 N. Meridian (8)

L

LaDine, C. B. . . . 2440 Station (18)
Lamb, Emmett B. 205 Hume Mansur Bldg. (4)
Lamb, Russell W. 205 Hume Mansur Bldg. (4)
Lamber, Chet K. 912 Hume Mansur Bldg. (4)
Langdon, Harry K. (H) 3264 N. Penn. (5)
Laramore, Ward Billings VA Hosp. (16)
Larkin, Bernard J. 305 Hume Mansur Bldg. (4)
Lawler, G. F. . . . . 3934 E. 10th (1)
Lawrence, Edwin A. I.U. Med. Center (7)
Layman, D. W. (H) 3256 N. Penn. (5)
Leasure, J. Kent 611 Hume Mansur Bldg. (4)
Leatherman, Harter L. 1531 Broadway (2)

MARION COUNTY
(Indianapolis—Continued)

Leff, Abe H.....712 E. 52nd (5)
Leffel, James M., Jr.
3209 N. Meridian (8)
Leonard, Henry S. (H)
303 Hume-Mansur Bldg. (4)
Leser, Ralph U.
207-8 Hume Mansur Bldg. (4)
Levi, Leon.....40 W. 38th (8)
Levin, R. T...3209 N. Meridian (8)
Libbert, Edwin L.
VA Regional Office (4)
Lichtenberg, Melvin
535 E. 38th (5)
Lidikay, Edward C.
915 Hume Mansur Bldg. (4)
Lindenborg, Paul G.
1402 N. Olney (1)
Lingeman, Raleigh E.
411 Hume Mansur Bldg. (4)
Lingeman, Roger E.
4143 Blvd. Place (8)
Link, Goethe
608 Ind. Pythian Bldg. (4)
Littell, J. Jerome
603 Hume Mansur Bldg. (4)
Little, J. W. (H)..2735 E. 10th (1)
Little, William J...VA Hosp. (22)
Littlefield, Paul A.
I.U. Medical Center (2)
Lochry, Ralph L.
St. Vincent's Hosp. (7)
Loehr, William M.
712 Hume Mansur Bldg. (4)
Loomis, Norman S.
804 Hume Mansur Bldg. (4)
Lord, G. C....104 E. Maple Rd. (5)
Lorman, James G.
I.U. Med. Center (7)
Love, G. N....Methodist Hosp. (7)
Ludwig, O. D. ...5433 Madison (3)
Lukemeyer, George T.
I.U. Med. Center (7)
Lybrook, William B.
3749 N. Keystone (18)

M

MacDonald, John A.
408 Hume Mansur Bldg. (4)
MacDonnell, Thomas M.
2602 W. Washington St. (22)
McArt, Bruce A. General Hosp. (7)
McBride, James S.
810 Hume Mansur Bldg. (4)
McCallum, J. T. C..237 W. 46th (8)
McCarthy, Daniel J. (H)
507 Hume Mansur Bldg. (4)
McCartney, D. H.
918 Hume Mansur Bldg. (4)
McCaskey, Carl H.
608 Guaranty Bldg. (4)
McClain, Edwin S.
St. Vincent Hosp. (7)
McCormick, C. O., Jr.
621 Hume Mansur Bldg. (4)
McCormick, C. O., Sr.
621 Hume Mansur Bldg. (4)
McCown, Percy E.
521 Hume Mansur Bldg. (4)
McDevitt, Daniel R.
3202 N. Meridian (8)
McGrath, M. F..1929 E. 38th (18)
McGuff, P. E..605 E. Maple Rd. (5)
McIntire, Clarence R.
3202 Meridian (8)
McIntyre, Charles J.
414 Hume Mansur Bldg. (4)
McIntyre, J. M.
2901 N. Meridian St. (8)
McKay, Robert
Central State Hosp. (22)
McKechnic, Franklin B.
I.U. Medical Center (7)
McKinley, A. David
I.U. Hospitals (7)
McLelland, Mary E.
I.U. Medical Center (7)
McMillan, Frederick G.
1110 Odd Fellows Bldg. (4)
McNamara, J. P..5610 College (20)
McQuiston, Ralph J.
608 Guaranty Bldg. (4)
McTurnan, Robert W.
5646 N. Illinois (8)
Mackey, H. S.....4309 Central (5)
Mackey, J. E. ..General Hosp. (7)
Madtson, A. R.
601 Hume Mansur Bldg. (4)
Magennis, H. L..468½ W. Wash. (4)
Manalan, M. M.....VA Hosp. (22)
Manion, Marlow W.
601 Hume Mansur Bldg. (4)
Mann, Mortimer
323 Hume Mansur Bldg. (4)
Manning, J. C., Jr.
1015 Hume Mansur Bldg. (4)
Manning, K. Randolph
723 Hume Mansur Bldg. (4)
Marks, Maurice I.
2901 N. Meridian St. (8)
Marshall, A. L., Jr.
3465 Carrollton (5)
Marshall, C. R.....43 W. 30th (8)
Martin, H. E.....1200 Madison (6)
Martin, L. H..2626 W. Wash. (22)
Martz, Bill L....General Hosp. (7)
Martz, Carl D.
508 Hume Mansur Bldg. (4)
Marvel, R. J. 3311 N. Meridian (8)
Masters, John M.
805 Hume Mansur Bldg. (4)
Masters, Robert J.
805 Hume Mansur Bldg. (4)
Matthew, W. Burleigh
520 Hume Mansur Bldg. (4)
Matthews, B. J....4612 E. 10th (1)
Matthews, W. M...4612 E. 10th (1)
Megenhardt, D. S.
1015 Hume Mansur Bldg. (4)
Meiks, Lyman T....Riley Hosp. (7)
Melloh, A. F.....2821 E. 10th (1)
Mendenhall, Clarence D.
4502 E. Wash. (1)
Mentendiek, Maurice H.
205 Hume Mansur Bldg. (4)
Mericle, Earl W.
920 Hume Mansur Bldg. (4)
Merrell, Paul
914 Hume Mansur Bldg. (4)
Mertz, H. O....1711 N. Capitol (7)
Michael, A. C...1040 W. Mich. (7)
Micheli, Arthur J.
920 Underwriters Bldg. (4)
Middleton, H. N....1828 N. Ill. (2)
Miller, Iva M...2458 N. Kitley (18)
Miller, J. Don
514 Hume Mansur Bldg. (4)
Miller, John R.....953 E. Tabor
Miller, R. S.....6211 College (20)
Miller, Wallace E..Riley Hosp. (7)
Millikan, William J.
3736 N. Delaware (5)
Mitchell, E. H.....1023 King (22)
Moenning, Walter P.
618 K. of P. Bldg (4)
Molt, William F.
529 Bankers Tr. Bldg. (4)
Montgomery, William F.
311 Hume Mansur Bldg. (4)
Moore, Ben B.
414 Hume Mansur Bldg. (4)
Moore, H. T...3220 N. Sharon (22)
Moore, Robert M.
5617 N. Meridian St. (8)
Morchan ,Saml....3769 College (5)
Morec, G. J.....General Hosp. (7)
Morgan, Margaret E.
I.U. Medical Center (7)
Moriarty, John R.
5602 Madison (3)
Morrison, Lewis E.
503 Hume Mansur Bldg. (4)
Morton, Walter P.
623 Hume Mansur Bldg. (4)
Moser, Rollin H.
400 Hume Mansur Bldg. (4)
Moss, H. B...18 W. Georgia St. (4)
Mothersill, M. H..Eli Lilly & Co. (6)
Moulton, L. G....1327 N. Penn. (2)
Mozingo, Arvine E.
1129 S. Meridian (25)
Mueller, L. B....General Hosp. (7)
Muller, L. P.....5608 College (20)
Muller, P. F..3311 N. Meridian (8)
Mumford, E. B 320 N. Meridian (4)
Myers, Chas. W..General Hosp. (7)
Myers, Paul W. ..General Hosp. (7)
Myers, R. V....1904 N. Rural (18)

N

Nafe, Cleon A.
822 Hume Mansur Bldg. (4)
Nagan, Robert F.
1434 N. Delaware (2)
Nay, Richard M.
1007 Hume Mansur Bldg. (4)
Need, L. T...1927 S. Meridian (25)
Neely, Alonzo S.
305 Fountain Sq. Bldg. (3)
Nehil, Lawrence W.
1011 Hume Mansur Bldg. (4)
Neier, O. C.(H)..5508 E. Wash. (19)
Nester, H. G.
720 Underwriters Bldg. (4)
Nie, Louis W.
2901 N. Meridian St. (8)
Noble, Thomas B., Jr.
1008 Hume Mansur Bldg. (4)
Nodurft, Joseph H.
I.U. Medical Center (7)
Noe, Wm. R...Methodist Hosp. (7)
Nolting, H. F.....261 W. 40th (8)
Norman, Olin B.
922 Hume Mansur Bldg. (4)
Norman, William H.
908 Hume Mansur Bldg. (4)
Norris, Howard Lee
704 Hume Mansur Bldg. (4)
Norris, Max S.
I.U. Medical Center (7)
Nourse, M. H..1711 N. Capitol (7)
Nugent, E. J..Allison Div. GMC (6)

O

Ochsner, H. C..Methodist Hosp. (7)
O'Dell, Thomas A..1122 Roache St.
O'Malley, Martha
1330 W. Michigan St. (7)
Olvey, O. N. ..3769 Park Ave. (5)
Orders, Clark E.
440 Bankers Tr. Bldg. (4)

MARION COUNTY
(Indianapolis—Continued)

Otten, Claude F.
812 C. of C. Bldg. (4)
Ottinger, Ross C.
912 Hume Mansur Bldg. (4)
Owen, John E.
605 Hume Mansur Bldg. (4)
Owens, T. C. 2823 N. Meridian (8)

P

Pandolfo, Harry 2206 Madison (25)
Park, Byron J.
1104 N. Tuxedo St. (1)
Parker, G. F., Jr.
1517 N. Emerson (19)
Parker, J. F. 1706 E. Wash. (1)
Parker, Portia 2226 W. Mich. (22)
Patton, M. T. 107 W. 30th (8)
Paulissen, G. T. 310 E. 24th (5)
Pearson, Lyman R.
311 Hume Mansur Bldg. (4)
Pebworth, Aubrey C.
1625 W. Morris (21)
Peck, F. B. 740 S. Alabama (6)
Peirce, J. D. Eli Lilly & Co. (6)
Pennington, Walter E.
214 Hume Mansur Bldg (4)
Permer, Erwin 134 E. 30th (5)
Peters, R. J. D. 3203 E. Mich. (1)
Petranoff, T. V. 3367 W. Mich. (22)
Pettijohn, Fred L. (H)
2460 Central (5)
Pfaff, Dudley
VA Regional Office (4)
Pfaff, John A. (H)
703 Hume Mansur Bldg. (4)
Pfafflin, Charles A. (H)
6046 Riverview (20)
Phipps, Elwood B.
1064 W. 37th St. (23)
Pickett, Robert D.
400 Hume Mansur Bldg. (4)
Pilcher, Jack E.
201 Hume Mansur Bldg. (4)
Pollak, Lewis 1602 N. Penn. (2)
Pontius, Edwin E. Camp Atterbury
Popplewell, Arvine G.
Sunnyside Sanitarium
Price, James O.
906 Hume Mansur Bldg. (4)
Pryor, R. C. 6111 College (20)

Q

Quigley, Jos. B. 2120 E. 10th (1)

R

Rabb, Frank M. 4146 N. Ill. (8)
Rabb, H. S. 3139 E. 10th (1)
Raber, Robt. M. VA Hosp. (22)
Rader, George S.
624 Hume Mansur Bldg. (4)
Radigan, L. R. I.U. Med. Center (7)
Ramsey, Frank B.
201 Hume Mansur Bldg. (4)
Rawdon, Robert E.
General Hospital (7)
Reed, Jewett V.
820 C. of C. Bldg. (4)
Reed, Philip B. 1800 E. 10th (1)
Rees, R. C. 6114 E. Wash. (19)
Reid, Chas. A. 2445 Shelby (3)
Reisler, Simon
318 Bankers Tr. Bldg. (4)
Rhodes, Theodore D.
307 Hume Mansur Bldg. (4)
Rice, R. M. 740 S. Alabama (6)
Rice, T. B.
1330 W. Michigan St. (7)
Richardson, Thad T.
513 S. Sherman Dr. (3)
Richter, Arthur B.
720 Hume Mansur Bldg. (4)
Ricketts, J. W.
2901 N. Meridian St. (8)
Ridgeway, O. W. 411 E. 16th (2)
Rigg, John F.
421 Hume Mansur Bldg. (4)
Rinker, Earl B. 22 E. 57th St.
Ritchey, James O.
608 Hume Mansur Bldg. (4)
Ritter, Wayne L.
404 Hume Mansur Bldg. 4)
Robb, John A.
238 Hume Mansur Bldg. (4)
Robertson, R. B 6118 E. Wash. (19)
Roesch, Ryland
Central State Hosp. (22)
Rogers, Donald L.
3311 N. Meridian St. (8)
Rohn, Robert J.
420 Hume Mansur Bldg. (4)
Roller, C. W. 1437 Shelby (3)
Romberger, F. T., Jr.
3440 N. Meridian (8)
Rosenak, Bernard D.
226 Hume Mansur Bldg. (4)
Rosenbaum, David VA Hosp. (22)
Rosenbaum, Irving, Jr.
401 E. 34th St. (5)
Ross, A. T. I.U. Med. Center (7)
Roth, Bertram
6378 College Ave. (20)
Rothring, H. E. General Hosp. (7)
Row, D. Hamilton
906 Hume Mansur Bldg. (4)
Rubin, Gerald S.
620 Hume Mansur Bldg. (4)
Ruch, Jake D. General Hosp. (7)
Ruddell, Karl R.
3202 N. Meridian (8)
Ruddell, Keith R.
3202 N. Meridian (8)
Rudesill, Cecil L.
405 Hume Mansur Bldg. (4)
Rudolph, Stephen J., Jr.
1638 N. Meridian (2)
Rupel, Ernest
419 Hume Mansur Bldg. (4)
Rust, B. K. 3740 Central (5)
Ruth, M. L. 4304 E. Wash. (1)
Rutherford, C. W. (H)
4601 N. Penn. (5)
Ryan, G. V. 2428 W. 16th (22)

S

Sacks, Harry J. VA Hospital (22)
Sage, Russell A.
505 Hume Mansur Bldg. (4)
Salb, Max C. 826 C. of C .Bldg. (4)
Salzman, Morris
1119 S. Meridian (25)
Sanders, Harry M.
3760 N. Sherman Dr. (18)
Sandorf, Marvin 1102½ Prospect (3)
Schaefer, C. Richard (H)
224 N. Meridian, No. 20 (4)
Schechter, John S.
3209 N. Meridian (8)
Scheier, E. W. 1542 Prospect (3)
Schlaegel, T. F., Jr.
I.U. Med. Center (7)
Schmidt, L. F. Methodist Hosp. (7)
Schmidt, R. H. Methodis tHosp. (7)
Schneider, C. J. 1008 N. Beville (1)
Schuchman, Abe
5878 Washington Blvd. (20)
Schuchman, Gabriel
3451 College (5)
Schulze, Hans A. 98 N. Ewing (1)
Schuster, Dwight W.
723 Hume Mansur Bldg. (4)
Schweitzer, Ada E. (H)
5736 Michigan Rd. (20)
Scott, Geo. 3340 N. Meridian (8)
Scott, I. W. 3209 N. Meridian (8)
Scott, J. S. I.U. Med. Center (7)
Scott, R. P. St. Vincent's Hosp. (7)
Scott, S. L. 712 E. 63rd St. (20)
Seagle, William C.
General Hosp. (7)
Seaman, Charles F.
1010 Hume Mansur Bldg. (4)
Sedam, H. L. 4173½ College (5)
Segar, Louis H.
226 Hume Mansur Bldg. (4)
Seidell, Martin A.
4305 Crittenden (5)
Seitz, Philip F. D.
I.U. Med. Center (7)
Sexson, H. T. 1301 College (2)
Shafer, Marion R.
614 Hume Mansur Bldg. (4)
Sheehan, F. G. 5503 E. Wash. (19)
Sherster, H. 1135 S. Meridian (25)
Shrigley, Edward W.
I.U. Med. Center (7)
Shugart, Joseph A.
St. Vincent's Hosp. (7)
Shullenberger, W. A.
3740 Central (5)
Shumacker, Harris B., Jr.
I.U. Med. Center (7)
Sicks, Okla W.
1010 Hume Mansur Bldg. (4)
Sidebottom, Earl. Meth. Hosp. (7)
Siekerman, C. W. 2612 Madison (3)
Siersdorfer, Theodore N.
6003 W. Wash. (21)
Sigmond, Harvey W.
301 Hume Mansur Bldg. (4)
Silver, Richard A.
I.U. Medical Center (7)
Simms, J. Leon
2638½ Northwestern (23)
Simpson, W. D. 6104 E. 21st (18)
Sims, J. Lawrence
809 Hume Mansur Bldg. (4)
Sluss, D. H. 808 C. of C. Bldg. (4)
Sluss, John W. (H)
808 C. of C. Bldg. (4)
Smith, D. J.
817 Hume Mansur Bldg. (4)
Smith, David L.
2901 N. Meridian St. (8)
Smith, E. Rogers
822 Hume Mansur Bldg. (4)
Smith, F. C. 983 N. Arlington (19)
Smith, Jas. M.
600 Terminal Bldg. (4)
Smith, Lester A.
238 Hume Mansur Bldg. (4)
Smith, Roy Lee
707 Underwriters Bldg. (4)
Smith, W. F. 3424 College (5)
Smith, William B.
2229 Northwestern (23)
Snider, Byron 2717 S. East (3)
Solomon, Reuben A.
414 Hume Mansur Bldg. (4)
Souter, M. C. 3360 N. Meridian (8)

MARION COUNTY

(Indianapolis—Continued)

Sovine, J. W.
720 Hume Mansur Bldg. (4)
Spahr, John F., Jr.
902 Hume Mansur Bldg. (4)
Spalding, Joseph J.
706 Hume Mansur Bldg. (4)
Sparks, Alan L.
1024 Hume Mansur Bldg. (4)
Spink, Urbana....112 E. 13th (2)
Spivey, R J....2616 N. Penn. (5)
Spolyar, L. W...1330 W. Mich. (7)
Sputh, Carl B., Jr.
301 Doctors Bldg. (4)
Sputh, Carl B., Sr.
301 Doctors Bldg. (4)
Stadler, H. E...5508 E. Wash. (19)
Stanley, J. S....307 City Hall (4)
Stayton, Chester A., Jr.
313 Hume Mansur Bldg. (4)
Stayton, Chester A., Sr.
313 Hume Mansur Bldg. (4)
Stephens, D. E..6332 Guilford (20)
Stephens, K. H.
501 Hume Mansur Bldg. (4)
Stern, Nathan
601 Bankers Tr. Bldg. (4)
Stevens, S. L.
303 Hume Mansur Bldg. (4)
Sthair, Phillip L.
General Hospital (7)
Stillwell, William R.
General Hospital (7)
Stoelting, V. K.
I.U. Med. Center (7)
Stone, A. T....6202 College (20)
Stone, David F.
725 Hume Mansur Bldg. (4)
Storey, D. Edmund
813 Broad Ripple Ave. (20)
Storey, Jos. L....3434 N. Ill. (8)
Storms, Roy B.
1014 Roosevelt Bldg. (4)
Stout, Francis E.
I.U. Med. Center (7)
Stroup, T. J. 216 K. of P. Bldg. (4)
Stucky, E. K....1355 Madison (25)
Study, Robert S.
General Hosp. (7)
Stump, Thomas A.
127 Blue Ridge Rd. (8)
Stygall, James H.
1221 N. Delaware (2)
Sudranski, Herbert F.
624 Hume Mansur Bldg. (4)
Sutton, William E.
419 Hume Mansur Bldg. (4)
Swan, John R.
915 Hume Mansur Bldg. (4)
Swayne, J. F....1410 E. Wash. (1)
Symmes, Alfred T.
605 E. Maple Rd. (5)
Szynal, Jno. S..633 E. 38th St. (5)

T

Talbott, Dan E.
1020 Hume Mansur Bldg. (4)
Tanner, Henry S.
301 Hume Mansur Bldg. (4)
Taylor, Clifford C.
St. Vincent's Hosp. (7)
Taylor, Frederic W.
400 Hume Mansur Bldg. (4)
Teague, Frank W.
918 Hume Mansur Bldg. (4)
Teixler, Victor A.
224 Hume Mansur Bldg. (4)
Test, Charles E.
1002 Hume Mansur Bldg. (4)
Test, Pasquale S.
General Hosp. (7)
Tether, J. E...I.U. Med. Center (7)
Tetrick, Elbert L.
General Hosp. (7)
Tharp, Harold R.
Methodist Hosp. (7)
Tharpe, Ray..3202 N. Meridian (8)
Thatcher, Hugh K., Jr.
110 W. Maple Rd. (8)
Thom, J. W....VA Reg. Office (4)
Thom, Julia S....1820 E. 10th (1)
Thomas, Edw. P.
820 W. Michigan St.
Thomas, Fred A.
St. Vincent's Hosp. (7)
Thomas, L. I.
1008 Hume Mansur Bldg. (4)
Thomas, Morris E.
445 N. Penn., No. 715 (4)
Thompson, Charles F.
818 Hume Mansur Bldg. (4)
Thompson, John V.
1221 N. Delaware (2)
Thompson, Paul D.
404 Hume Mansur Bldg. (4)
Thornburg, Kenneth E.
1015 Hume Mansur Bldg. (4)
Thornton, H. C.
3769 College Ave. (5)
Thrasher, John R.
823 C. of C. Bldg. (4)
Thurston, H. S..2503½ Prospect (3)
Tindall, George T.
General Hosp. (7)
Tinney, William E.
900 Underwriters Bldg. (4)
Tinsley, Frank W.
603 K. of P. Bldg. (4)
Tinsley, Walter B.
603 K. of P. Bldg. (4)
Tischer, E. Paul
208 Hume Mansur Bldg. (4)
Torrella, J. A....5324 W. 16th (24)
Toumey, Fred L.
529 Bankers Tr. Bldg. (4)
Travis, J. C.
805 Underwriters Bldg. (4)
Trusler, Harold M.
1015 Hume Mansur Bldg. (4)
Tuchman, J. H.....845 Grove (3)
Tucker, R. L...Eli Lilly & Co. (6)
Tucker, Warren S.
414 Hume Mansur Bldg. (4)

V

Vandivier, Robert M.
209 Hume Mansur Bldg. (4)
Van Dorn, Myron J.
3626 Clifton (23)
Van Fleet, Josephine
I.U. Med. Center (7)
Van Meter, C. P...3419 E. 10th (1)
Van Nuys, John D.
I.U. Med. Center (7)
Van Osdol, Harry A.
828 C. of C. Bldg. (4)
Van Tassel, C. J., Jr.
I.U. Med. Center (7)
Van Vactor, Helen D.
226 Hume Mansur Bldg. (4)
Vollrath, V. J.....5202 N. Ill. (8)
Voyles, Charles F. (H)
715 Underwriters Bldg. (4)

W

Waldo, J. Thayer
610 Hume Mansur Bldg. (4)
Walker, Frank C.
414 Hume Mansur Bldg. (4)
Walker, Robt. K....413 E. 34th (5)
Walther, J. E.3202 N. Meridian (8)
Ward, Joseph H.
2116 Boulevard Pl. (2)
Ward, W. C.....116 E. 49th (5)
Warfel, F. C.
VA Regional Office (4)
Warman, Alvah P.
1363 E. 38th St. (5)
Warren, J. C.
VA Regional Office (4)
Warriner, James B.
975 N. Emerson Ave. (19)
Warvel, John H.
614 Hume Mansur Bldg. (4)
Waterman, John
5435 N. Capitol (8)
Waymire, E. S....1827 College (2)
Wehrman, Jule O. (H)
504 Hume Mansur Bldg. (4)
Weigand, C. G..740 S. Alabama (6)
Weil, H. J....443 N. Hamilton (1)
Weinland, George C.
2934 E. 39th St. (5)
Weiss, Jason....4909 W. 15th (24)
Weller, Charles A.
3720 N. Delaware St.
West, Jos. L...6318 W. Wash. (21)
Westfall, B. K....2901 E. 38th (18)
Westfall, John B.
2961 N. Sherman Dr. (18)
Weyerbacher, A. F.
709 Hume Mansur Bldg. (4)
Wheeler, John T. (H)
3130 N. Delaware (5)
White, Donald J.
502 Bankers Tr. Bldg. (4)
White, Philip T..General Hosp. (7)
Whitehead, John M.
1544 Roosevelt (1)
Whitlock, F. C...4032 E. Wash. (1)
Wilkens, I. W.....1743 Shelby (3)
Williams, Chas. D. 2405 Station (1)
Williams, Howard S.
115 E. 16th St. (2)
Williams, Hugh L.
812 C of C Bldg. (4)
Williams, Luther (H)
3540 N. Penn. (5)
Wilson, Fred M.
I.U. Medical Center (7)
Wilmore, Ralph C.
I.U. Med. Center (7)
Wilson, O. R..3519 Wash. Blvd. (5)
Winters, Matthew..508 E. 38th (5)
Wise, Wm.....120 E. 22nd (2)
Wishard, Wm. Niles, Jr.
1711 N. Capitol (7)
Wolfram, Don J.
208 Hume Mansur Bldg. (4)
Wood, D. E....6325 Guilford (20)
Woodard, A. S., Jr.
668 E. Maple Rd. (5)
Worley, J. P....5831 E. Wash. (19)
Worley, Richard H.
General Hosp. (7)
Wright, J. William, Jr.
301 Hume Mansur Bldg. (4)
Wright, J. William, Sr.
301 Hume Mansur Bldg. (4)
Wyttenbach, F. C....1154 Lee (21)
Wyttenbach, John E.
503 Hume Mansur Bldg. (4)

MARION COUNTY

(Indianapolis—Continued)

Y

Young, J. M. 3209 N. Meridian (8)
Young, J. W. 6302 Guilford (20)
Young, W. C. Eli Lilly & Co. (6)

Z

Zaiac, Donald A.
General Hosp. (7)
Zell, E. H. 812 C. of C. Bldg. (4)
Zeps, E. F. Methodist Hosp. (7)
Zerfas, C. P. A. 2605 Shelby (3)
Zerfas, Phyllis K. 2605 Shelby (3)

Bartle, James L. Lawrence
Lewis, Robert J. Lawrence
Asher, E. O. New Augusta
Asher, James W. New Augusta
Paynter, Morris B. Southport
Jones, George L. Wanamaker

Barry, Maurice J., Jr.
Mayo Clinic, Rochester, Minn.
Bock, Don G.
517 S. Greene St., Boone, Iowa
Boyd, Foster J. 293 N. South St., Wilmington, Ohio
Brother, George M.
Univ. of Okla., Okla. City, Okla.
Bundy, Merle City Health Dept., Pittsburgh, Pa.
Burt, James C.
Sloane Hosp., New York, N.Y.
Connerly, Marion L.
U. S. Naval Hosp., San Diego, Calif.
Dester, Herbert E.
Jagdeeshpur Via Raipur, C. P. India
Fisher, Gerald
1120 Chester Ave., Cleveland 14, O.
Graf, John E. 4332 N. Kilbourn Ave., Chicago 41, Ill.
Griswold, Wait Robbins
U. S. Naval Hosp., Mare Island, Calif.
Harvey, Verne K.
39 River Road Terrace, Alexandria, Va.
Hull, Roland H.
U.S. Naval Hosp., Portsmouth, Va.
Kopp, Herschel S. 3069 Calle Pinon, Santa Barbara, Calif.
Lehman, Robert J. 2103 Eastern Pkwy., Louisville 4, Ky.
Masters, John B. French Clinic, San Luis Obispo, Calif.
Meihaus, John E. Sawtelle VA Hospital, Los Angeles, Calif.
Mitchell, Raymond E.
O'Reilly Veterans Hosp., Springfield, Mo.
Murray, James S. 606 N. Roxbury, Beverly Hills, Calif.
Norris, Mary Alice
A.P.O. 676, New York, N. Y.
Norwick, Sydney S.
15816 Via Riveria, San Lorenzo, Calif.
Pierce, William J. 145 Wash. Ave., Westville, Ill.
Radding, Robert S. 1562 Long Meadow St., Long Meadow, Mass.
Ridgway, Alton H.
Belgian Congo, Africa
Rogers, Thomas P. U. S. Naval Hosp., Philadelphia, Pa.
Rothenberger, Daniel J.
Walker Air Base, Roswell, N.M.
Rudesill, Robert L.
Mayo Clinic, Rochester, Minn.
Sheridan, Joseph L.
St. Elizabeth Hosp., Washington, D. C.
Soper, Hunter A. 1605 E. 7th St., Emmettsburg, Iowa
Strange, Dempsey C. Eckford Mem. Hosp., Starkville, Miss.
Terry, Willard B. G. Detroit Receiving Hosp., Detroit, Mich.
Teter, George V., Jr. Children's Med. Center, Boston, Mass.
Theye, Richard A.
USN Hosp., Portsmouth, Va.
Whitt, James D.
Baroness Erlanger Hosp., Chattanooga, Tenn.
Yochem, August S.
U.S.N. Hosp., Chelsea, Mass.
Ziperman, H. Haskell
Station Hosp., Fort Dix, N.J.

MARSHALL COUNTY

Kelly, Frank H. Argos
Sheller, Thomas G. Argos
Connell, Vactor O. Bourbon
Marshall, George L. Bourbon
Bowen, Otis Bremen
Cripe, Earl P. Bremen
Schreiner, John E. Bremen
Baker, Milan D. Culver
Bills, L. F. R.R. 1, Culver
Witham, Robert L. Culver
Connell, Paul S. Plymouth
Irey, Paul R. Plymouth
Kaler, James Plymouth
Klingler, Maurice O. Plymouth
Kubley, James Plymouth
Pomeroy, Rex K. Plymouth
Robertson, James S. Plymouth
Stephens, R. Clarence (H)
Plymouth
Vore, L. W. Plymouth
Thompson, Alfred A. Tyner
Holtzendorff, Charles F. (H)
2344 Oakdale St., St. Petersburg, Fla.
Stine, Marshall E. Columbus, Ga.

MARTIN COUNTY

(See Daviess-Martin)

MIAMI COUNTY

Shrock, Ethan E. Amboy
Line, Homer E. Chili
Frybarger, Samuel S. Converse
Malott, Frederick R. Converse
Sennett, Wm. K. Macy
Waite, Earl L. Gilead
Rendel, Harold E. Mexico
Barnett, Ralph E. Peru
Berkebile, John B. Peru
Burrous, E. L. Peru
Carlson, E. A. (H) Peru
Ferrera, Donald W. Peru
Ferrara, Samuel J. Peru
Herd, C. R. Peru
Johnson, Owen Peru
Lynn, Frank M. (H) Peru
Malouf, Stephen D. Peru
Wildman, Roscoe E. Peru
Yarling, John E. (H) Peru

MONROE COUNTY

(See Owen-Monroe)

MONTGOMERY COUNTY

Crawfordsville

Alexander, Stephen J.
306 Ben Hur Bldg.
Ball, T. Z. (H)
403 Ben Hur Bldg.
Burks, Jess Edwin
403 Ben Hur Bldg.
Cooksey, Thomas L. (H)
109½ S. Washington St.
Cornell, Robert A.
219 Ben Hur Bldg.
Daugherty, Fred N. 120 W. Pike St.
Dodds, Wemple Culver Hospital
Haller, Thomas C.
419 Ben Hur Bldg.
Humphreys, John W.
312 Jones Ave.
Kinnaman, Howard A.
206 Ben Hur Bldg.
Kirtley, James M.
416 Ben Hur Bldg.
Lingeman, Byron N.
419 Ben Hur Bldg.
Mount, Wm. M. 413 Ben Hur Bldg.
Peacock, Norman F.
219 Ben Hur Bldg.
Pierson, Robert H. 305 E. Main St.
Pollom, Robt. 306 S. Water St.
Sharp, John L. 219 Ben Hur Bldg.
Taylor, W. Mitchell
315 Ben Hur Bldg.
Wallace, Hawthorne C.
419 Ben Hur Bldg.

Otten, Ralph E. Darlington
Blix, Fred M. Ladoga
Denny, Frank T. Ladoga
Davis, William New Market
Kindell, Hurschell D.
New Richmond
Hendrix, Claude A. Waveland
Bounnell, Harry M. (H)
Waynetown
Johnson, Frank D. Waynetown
Parker, Carl B. Wingate

MORGAN COUNTY

Alexander, P. M. Martinsville
Bothwell, Camden G. Martinsville
Eisenberg, David A. Martinsville
Farr, James C. Martinsville
Gray, Leon Martinsville
Grimes, Jay H. Martinsville
Miller, Ray D. Martinsville
Pitkin, Edward M. Martinsville
Pitkin, McKendree C. Martinsville
Willan, Horace R. Martinsville
Murphy, Maurice G. Morgantown
Seibel, Robert M. Morgantown
Comer, Charles W. Mooresville
Comer, Jonathan E. Mooresville
Comer, Kenneth E. Mooresville
Karpel, Bernard Mooresville
VanBokkelen, Robert W.
Mooresville

NEWTON COUNTY

(See Jasper-Newton)

NOBLE COUNTY

Bowman, Charles M. .....Albion
Morr, John W. (H) .....Albion
Nash, Justin R. .....Albion
Sneary, Kenneth D. .....Avilla
Veazey, Wm. M. (H) .....Avilla
Bryan, Robert E. .....Kendallville
Clark, Joseph H. .....Kendallville
Goodwin, Columbus B. (H)
Kendallville
Gutstein, Richard R....Kendallville
Lawson, Isaac H.....Kendallville
Messer, Frank W.....Kendallville
Munk, Cleorie E.....Kendallville
Seybert, Joseph D.....Kendallville
Williams, Harold O....Kendallville
Young, Simon J. (H)..Kendallville
Harlin, Wm. L. .....Ligonier
Schutt, James B. .....Ligonier
Stultz, Quentin F.....Ligonier
Fipp, August L. .....Rome City
Pulskamp, Bertrand H.
Wolcottville
Luckey, Harold A.....Wolf Lake
Luckey, Robert C.....Wolf Lake
Roth, James R.....Wolf Lake
Switzer, Robert E.
Colo. Psychopathic Hosp., Denver
Fair, John R.
1011 Peachtree St., Augusta, Ga.

OHIO COUNTY

(See Dearborn-Ohio)

ORANGE COUNTY

Keseric, Nicholas E....French Lick
Sugarman, Benj. E....French Lick
Take, John F. (H)....French Lick
Colglazier, Granville G.....Leipsic
Baker, Robert E. (H).....Orleans
Hodgin, Philip .....Orleans
Schoolfield, Wm. E. .....Orleans
Clark, Ivan A. .....Paoli
Hammond, Keith .....Paoli
Spears, John K. .....Paoli
Teaford, Schulyer F. .....Paoli
Boyd, Clarence E.....West Baden
Miller, Henderson L....West Baden

OWEN-MONROE COUNTIES

Bloomington

Austin, Fred H. (H) .110 E. 4th St.
Baxter, Neal E.....306 E. 5th St.
Borland, Raymond M.
114 N. Lincoln St.
Buckingham, Richard E.
344 College Ave.
Culmer, Walter N. (H)
432 S. College Ave.
Dalton, Naomi L.....114 E. 7th St.
DeMotte, Russell..214 E. Kirkwood
Estes, Ambrose C..300½ E. 5th St.
Fowler, Richard R.
108 S. Washington
Geiger, Dillon D...300 E. Kirkwood
Hardtke, Eldred F.
Indiana University
Hepner, Herman S..312 N. Walnut
Holland, Charles E.
712 N. Washington St.
Holland, Deward J.
313 N. College Ave.
Holland, Philip T....108 W. 7th St.
Karsell, William A.
306 East Kirkwood
Lutes, D. L.....R. R. 5
Luzadder, John E. (H)
123½ W. 5th St.
Lyons, Robert E.....321 E. 5th St.
Marchant, Clarence H.
350 S. College
Middleton, Thos. O...404 E. 7th St.
Miller, Mary E.....701 E. 10th St.
Owen, Abraham M.
200 S. Washington St.
Owen, Margaret A.
200 S. Washington St.
Owens, Walter L.
Student Health Ser., Ind. Univ.
Poolitson, George C.
407 N. Walnut St.
Prosser, William O. H.
1211 E. Maxwell Lane
Ramsey, Hugh S....307 E. 5th St.
Reed, William C.....307 E. 5th St.
Rogers, Otto F., Jr.
210 N. Washington St.
Rogers, Robert C. (H)
210 N. Washington St.
Ross, Ben R.....314 E. 7th St.
Schell, Harry D..114 N. Lincoln St.
Schuman, Edith B.
Indiana University
Smith, Herschel S.
218 E. Kirkwood
Smith, Paul E...812 North College
Smith, Rodney D. (H)
115 N. Washington St.
Spencer, Beaufort A.
114 N. Lincoln
Stangle, William J.
Bloomington Hospital
Topolgus, James N.
403 N. Walnut St.
Tripp, Harry D...205 S. Walnut St.
Wilson, Talmage L.
301 E. Kirkwood
Wiltshire, James W. (H)
103 S. Lincoln St.

Stouder, Charles E.....Gosport
Mitchell, George L. .....Smithville
Brown, Marcel S. .....Spencer
Greene, Claude D. .....Spencer
Kay, Oran E. .....Spencer
Pectol, Charles F.....Spencer
Smith, Frederick R. .....Spencer

PARKE-VERMILLION COUNTIES

Greene, Frederick G..Bloomingdale
Brown, Ralph E. .....Cayuga
Darroch, Samuel .....Cayuga
Casebeer, Paul B. .....Clinton
Evans, Frederick .....Clinton
Gerrish, Wakefield D.....Clinton
Kercheval, John M.....Clinton
Rosenfeld, Norman M.....Clinton
White, Isaac D. (H).....Clinton
Lauer, Dorothy B. .....Dana
Myers, William C. .....Dana
Warren, Bradford .....Marshall
Britton, Welbon D.....Montezuma
Saunders, Jones L.....Newport
Johnson, William A.....Perrysville
Bloomer, Joseph R.....Rockville
Bloomer, Richard S. .....Rockville
Dowell, Emil H. .....Rockville
Harstad, Casper .....Rockville
Merrell, Basil M. .....Rockville
Pirkle, Hubert B.
Ind. State Sanitarium, Rockville
Schaie, Milton
Ind. State Sanitarium, Rockville
Staff, Robert A.
Ind. State Sanitarium, Rockville
White, Chester S.....Rosedale
Green, Silva Ira.....St. Bernice
Keith, Freeman E. (H) .St. Bernice

PERRY COUNTY

Bush, Hargis R.....Cannelton
Coultas, Porter J. .....Tell City
Dome, Hardin S. (H).....Tell City
Dukes, David .....Tell City
Glenn, Fred C. .....Tell City
James, Nicholas A. .....Tell City
Lashley, Donald L.....Tell City
Neifert, Noel L. .....Tell City
Snyder, Earl R. .....Troy

PIKE COUNTY

Higgins, James L. .....Petersburg
Kime, John T. (H) .....Petersburg
Logan, Austin R. (H)..Petersburg
Omstead, Milton .....Petersburg
Rice, Thompson R. (H) .Petersburg
DeTar, George B. (H)....Winslow

PORTER COUNTY

Dale, Joseph W. .....Chesterton
Griffin, Joseph P.....Chesterton
Hall, Thomas C.....Chesterton
Harless, Clarence M....Chesterton
Butman, William C.....Hebron
Kleinman, Francis J.....Hebron
Dittmer, Samuel E.....Kouts
Brown, James C. .....Valparaiso
Davis, Carl M. .....Valparaiso
DeGrazia, Eugene .....Valparaiso
DeWitt, Charles E. (H) .Valparaiso
Dittmer, Jack E.....Valparaiso
Douglas, Geo. R. (H)...Valparaiso
Eades, Ralph C.....Valparaiso
Frank, John R. .....Valparaiso
LaRocca, Joseph .....Valparaiso
Loring, Mark L. .....Valparaiso
Makovsky, Theodore ...Valparaiso
Miller, Ebbo H. .....Valparaiso
Nash, Charles B. .....Valparaiso
VanWinkle, Arthur J....Valparaiso
Vietzke, Paul C. F.....Valparaiso
Gordon, Joseph L.....Wheeler

POSEY COUNTY

Montgomery, Samuel B. (H)
Cynthiana
Ropp, Harold E.....New Harmony
Thompson, Lewis R..New Harmony
Boren, Paul .....Poseyville
Boren, Samuel W. (H)..Poseyville
Woods, Arba L. .....Poseyville
Challman, William B...Mt. Vernon
Herr, John W. .....Mt. Vernon
Oliphant, Frank W.....Mt. Vernon
Ranes, John R. .....Mt. Vernon
Vogel, L. John .....Mt. Vernon
Williams, Frederic ....Mt. Vernon

PULASKI COUNTY

Dublin, Madeline .....Francesville
Ives, Raymond J.....Francesville
Linton, Charles E. ....Medaryville
Carneal, Thomas E.....Winamac
Halleck, Harold J. .....Wilnamac
McCaskey, George H.....Winamac
Thompson, William R....Winamac

PUTNAM COUNTY

Veach, Lester W.....Bainbridge
Veach, Richard L.....Bainbridge
Gray, Clyde C. .....Cloverdale
Huckleberry, Carl D....Cloverdale
Dettloff, Frederick ....Greencastle
Dobbs, O. R. .....Greencastle
Fuson, Wenfred J. ....Greencastle
Gillespie, Joseph F. (H)
Greencastle
Hutcheson, Walter R. (H)
Greencastle
Johnson, James B.....Greencastle
Nichols, Anne Sackett.Greencastle
Parker, George F.....Greencastle
Rhea, Gilbert D.....Greencastle
Schauwecker, Cleon M..Greencastle
Steele, Dick J. .....Greencastle
Tennis, George T.....Greencastle
Tipton, William R.....Greencastle
Wiseman, V. Earle....Greencastle
Gwaltney, Loral F.....Roachdale
Osborne, Harry S..R.R.1, Roachdale
Richards, Edgar E.....Russellville

RANDOLPH COUNTY

Nixon, Byron .....Farmland
White, Harvey E. .....Farmland
Harmon, Wayne .....Lynn
Jordan, Leo E. .....Lynn
Martin, Charles E. .....Lynn
Slick, Crystal R. .....Lynn
Shallenberger, Henry R.....Modoc
Hinchman, Jean .....Parker
Henderson, Arvin .....Ridgeville
Potter, Richard M.....Ridgeville
Schenk, George H.....Ridgeville
Chambers, Leroy B.....Union City
Gullett, Charles C.....Union City
Phipps, Leland K.....Union City
Reid, Robert W.....Union City
Ruby, Fred M. .....Union City
Voisinet, Raymond A....Union City
Wills, Benjamin F.....Union City
Brenner, Ivan E. .....Winchester
DeRyke, Gilbert R.....Winchester
Dininger, William S....Winchester
Engle, Russell B.....Winchester
Painter, Lowell W.....Winchester
Robison, John S. .....Winchester
Sparks, Paul W. .....Winchester

RIPLEY COUNTY

Hisrich, Lloyd W. .....Batesville
Lippoldt, Charles L.....Batesville
Obery, George A. .....Batesville
Conrad, Henry W. .....Milan
Hunter, Lowell G. .....Milan
Warn, William J. .....Milan
Row, George S. .....Osgood
Smith, R. Lee .....Osgood
McConnell, William C.....Sunman
Fletcher, Charles F.....Sunman
Hopkins, Lester H.....Versailles
Moran, Noel D. .....Versailles

RUSH COUNTY

McNabb, George B. .....Carthage
Worth, C. Willard .....Milroy

Rushville

Atkins, C. C. .....225 N. Morgan
Corpe, Kenneth F. .....Rushville
Dean, Donald I.....310 E. Fifth
Denny, Melvin H.....127 W. Third
Ellis, Davis W...4th and Main Sts.
Green, Frank, Jr....134 E. Second
Johnson, Robt. B....229 N. Morgan
Kennedy, Robt. O.....118 W. Third
Nutter, W. H. .....205 W. Third
Shanks, Roy E.....I.O.O.F. Bldg.
Truman, Elmer M...733 N. Morgan

ST. JOSEPH COUNTY

Houser, D. Stanley .....Lakeville
How, John T. (H) .....Lakeville

Mishawaka

Barone, C. V....312 Lincolnway W.
Bassler, C. R..Mishawaka Tr. Bldg.
Christophel, Verna...109 W. Third
Ganser, Richard A.
114 Lincolnway W.
Goethals, C. J...602 Lincolnway W.
Joest, Charles O.....113 S. Church
Logan, Francis W.
208 First Nat. Bk. Bldg.
Martin, Charles F...224 S. Mill St.
Orr, Robert .....124 S. Race
Rosenwasser, Jacob
228 Lincolnway East
Sirlin, Edw. M.....109 S. Church
Spalding, Wendell L.
212 First Nat. Bk. Bldg.
Templeton, A. R...522 Calhoun St.
Van Rie, Leo P.....116 S. West
Walerko, Frank....204 Polis Bldg.
Walters, Charles...206 Polis Bldg.
Ward, Jas. W...316 Lincolnway W.
Whitlock, Merle E...123 W. Fourth
Wixted, Jno. F..114 Lincolnway W.
Wixted, Julia F.
114 Lincolnway, W.
Wurster, Herbert C...221 E. Third
Wygant, Marion D....116 W. Third
Wyland, Byron J.....116 W. Third
Zimmer, H. J..119½ Lincolnway W.

Luzadder, John E., Jr..New Carlisle
Hardy, John J. .....North Liberty
Warrick, Homer Lyle.....Osceola

South Bend

A

Abel, Joseph A..1222 Western Ave.
Acker, Robert B.
418 Sherland Bldg.
Arisman, Ralph K.
711 Odd Fellow Bldg.

B

Balla, Morris ...404 Sherland Bldg.
Baran, Charles.....128 Tasher St.
Bartsch, Harvey L.
1909 S. Michigan St.
Bechtold, Samuel E.
730 Sherland Bldg.
Bennett, Jene R.....531 Main St.
Bergan, Joseph A....828 E. Colfax
Berke, Robert D.
102 E. Colfax Ave.
Biasini, Benedict A.
401 Dixie Way North
Bickel, David A.
515 Odd Fellows Bldg.
Birmingham, Peter J.
426 Sherland Bldg.
Bishop, Charles A.
122 N. Lafayette Blvd.
Bixler, Louis C..615 Sherland Bldg.
Blackburn, Erwin
508 Sherland Bldg.
Bodnar, Leslie M.
215 Poledor Bldg.
Bolka, Bernard .....728 W. Colfax
Borough, L. D.....710 J.M.S. Bldg.
Bryan, Robert J.
1002 Lincolnway W.
Buchanan, Wallace D.
825 Sherland Bldg.
Buechner, Frederick W.
116 N. Main St.
Burket, Cecil R. ...530 N. Main St.
Bussard, Clifford F.
634 Associates Bldg.
Bussard, Frank
634 Assoriates Bldg.

C

Carter, F. R. N..605 Sherland Bldg.
Cassady, James V.
525 Sherland Bldg.
Caton, Joseph R.
124 E. Pokagon St.
Chambers, William
706 Odd Fellows Bldg.
Clark, Stanley A.
1242 E. Jefferson St.
Clark, William H.
122 N. Lafayette Blvd.
Colip, George D.
514 Sherland Bldg.
Condit, David H.
122 N. Lafayette Blvd.
Cook, Gordon C.
122 N. Lafayette Blvd.
Cooper, Harry L.
410 Sherland Bldg.
Culbertson, Carl S..531 N. Main St.
Cunningham, Robert D.
604 N. Main St.
Custer, Edward W.
Healthwin Sanitarium

D

Denham, Robert H.
425 Odd Fellows Bldg.
Dietl, Ernest L..822 Sherland Bldg.
Dodd, Robert D...759 Portage Ave.
Dolezal, Bernard J.
530 N. Main St.
Donnelly, Everett F.
730 W. Indiana Ave.
Duggan, James A.
316 St. Joseph Bank Bldg.
Dunlap, D. Logan.716 J.M.S. Bldg.

E

Edwards, Bernard E.
226 Sherland Bldg.
Egan, Sherman.301 Sherland Bldg.
Ellison, Alfred..826 Sherland Bldg.
English, John P.
122 N. Lafayette Blvd.

ST. JOSEPH COUNTY

(South Bend—Continued)

Ericksen, Lester G.
615 Sherland Bldg.
Erickson, Gustaf W.
122 N. Lafayette Blvd.

F

Faltin, Ladislaus
609 Odd Fellows Bldg.
Feldman, Max.....1921 Miami St.
Filipek, Walter J.
311 Odd Fellows Bldg.
Firestein, Ben Z...703 J.M.S. Bldg.
Fish, Clyde M...723 Sherland Bldg.
Fish, Edson C.
401 N. Notre Dame Ave.
Fisher, Lawrence F.
825 Sherland Bldg.
Frank, Lyall L....534 N. Lafayette
Frash, DeVon W...306 J.M.S. Bldg.
Frey William B..209 Poledor Bldg.
Friedman, Morris S.
218 Poledor Bldg.
Frith, Gladys
521 W. Washington Ave.
Frith, Louis G.
521 W. Washington Ave.

G

Gates, George E.
122 N. Lafayette Blvd.
Gilman, Marcus M.
403 Odd Fellow Bldg.
Giordano, Alfred S.
531 N. Main St.
Godersky, George E.
512 Odd Fellows Bldg.
Goraczewski, Thaddeus C.
1016 W. Washington Ave.
Gordon, J. M.....726 J.M.S. Bldg
Green, G. F.....822 Sherland Bldg.
Green, Norval E.....Poledor Bldg.
Grillo, Donald..530 Sherland Bldg.

H

Haley, Paul E...401 Sherland Bldg.
Hall, James M..230 Sherland Bldg.
Hamilton, Chas. D.
1498 Northern Ave.
Harmon, V. E...302 Sherland Bldg.
Haugseth, Ellsworth K.
122 Lafayette Blvd.
Helmen, H. W...120 Franklin Place
Hewitt, M. I....315 Sherland Bldg.
Hilbert, J. W...410 W. Washington
Hillman, M. W..429 Sherland Bldg.
Hillman, W. H. (H)
429 Sherland Bldg.
Hoffman, R. V. 416 Sherland Bldg.
Holdeman, L. S...404 N. Lafayette
Holdeman, R. W..404 N. Lafayette
How, Louis E.....6107 S. Michigan
Hyde, C. C.....122 N. Lafayette
Johns, N. C....718 Sherland Bldg.

K

Kamm, B. A....526 Sherland Bldg.
Karn, John....728 W. Colfax Ave.
Knapp, Arthur L..2215 Mishawaka
Knode, K. T.....729 Sherland Bldg.
Kramer, Albert A.....1519 Miami
Kuhn, F. L.....1215 S. Michigan

L

Lane, William H.....604 N. Main
Lang, Joseph E....730 J.M.S. Bldg.
Langenbahn, Carl J.
206 Sherland Bldg.
Lionberger, John R.
615 Sherland Bldg.
Liss, E. C....317 Odd Fellow Bldg.
Lockhart, Philip B.
St. Joseph Hospital
Ludwick, H....2730 Lincolnway W.
Luthy, Karl R.
601 Whitcomb Keller Bldg.

M

Mason, Bernard A.
122 N. Lafayette Blvd.
McCraley, W. J..406 Sherland Bldg.
McDonald, R. M...410 J.M.S. Bldg.
McFarland, Corley B.
122 N. Lafayette Blvd.
McKenna, H. J.....1615 E. Wayne
McMeel, J. E..612 Associates Bldg.
Metcalfe, Grant E.
319 Odd Fellow Bldg.
Mikesch, W. H..816 Sherland Bldg.
Miller, Milo K.
122 N. Lafayette Blvd.
Miller, W. E....714 W. Washington
Mott, C. A..1301½ W. Washington
Mueller, Hilbert M.
122 N. Lafayette Blvd.
Murphy, Eugene C.
122 N. Lafayette Blvd.
Murphy, J. F.....625 J.M.S. Bldg.

N

Nelson, F. Dale.428 Sherland Bldg.
Nelson, R. E....510 Sherland Bldg.
Olney, T. A. (H) Country Club Rd.
Olson, K. L.....615 Sherland Bldg.

P

Parke, D. Davis...St. Joseph Hosp.
Pauszek, T. B..726 W. Washington
Petrass, A.....516 Sherland Bldg.
Plain, George
122 N. Lafayette Blvd.
Proudfit, Charles H.
525 Odd Fellow Bldg.
Pyle, H. D.....518 Sherland Bldg.

R

Rasmussen, Ruth F.
122 N. Lafayette Blvd.
Rigley, E. L.....408 Sherland Bldg.
Rodin, H. H.....422 Sherland Bldg.
Rosenheimer, G. M.....604 N. Main
Rubens, Eli.408 Odd Fellows Bldg.
Rudolph, Carl J....617 J.M.S. Bldg.

S

Sanderson, Robert B.
730 Sherland Bldg.
Sandock, I. ....402 Sherland Bldg.
Sandock, Louis F...406 Platt Bldg.
Sandoz, Harry H.
615 Odd Fellow Bldg.
Sandoz, L. A....720 Sherland Bldg.
Savery, C. E....230 Sherland Bldg.
Schiller, H. A. .510 Shérland Bldg.
Scott, F. M..122 N. Lafayette Blvd.
Selby, Keith E..407 Lincolnway W.
Sellers, Francis M.
1404 Lincolnway East
Sennett, C. M...318 Sherland Bldg.
Sensenich, R. L....203 J.M.S. Bldg.
Shelley, Edw.....728 W. Colfax
Shively, John A...531 N. Main St.
Skillern, P. G..1002 Bldg. & Ln. Tr.
Slominski, Harry H
708 Odd Fellow Bldg.
Spenner, R. W..726 Sherland Bldg.
Staunton, H. A...3023½ Mishawaka
Stiver, D. D.....822 Sherland Bldg.
Stratigos, Joseph S.
713 E. Jefferson Blvd.

T

Thompson, John M.
527 Sherland Bldg.
Thompson, Robert A.
530 W. Indiana Ave.
Thornton, M. J..825 Sherland Bldg.
Traver, P. C.....1010 Riverside Dr.

V-W

Vagner, S. Bernard
1303½ W. Washington
Vurpillat, Francis J.
132 N. Lafayette Blvd.
Wegner, W. C. (H)..616 W. Wash.
Weiss, Eugene..2521 S. Michigan
Wilhelm, A. M..628 Sherland Bldg.
Wilson, James ....409 J.M.S. Bldg.
Zeiger, Irvin..... 3201 Mishawaka

Linton, Charles D.....Walkerton
Nassef, George J.....Walkerton
Cline, Kenneth L. .....Wyatt
Brechtel, Harvey J.
Naval Dispensary,
Green Cove Springs, Fla.
Firestein, Ray
Cook Co. Hospital, Chicago, Ill.
Hoffman, Robert V., Jr.
Univ. of Chicago, Chicago, Ill.
Rowdabaugh, Marshall J.
Veterans Hosp., Hines, Ill.

SCOTT COUNTY

Bogardus, Carl R.....Austin
Hill, Thomas N. .....Scottsburg
McClain, Marvin L. ....Scottsburg
Napper, Floyd S.....Scottsburg

SHELBY COUNTY

Nigh, Rufus M. .....Fairland
Davis, John A. .....Flat Rock
Nave, H. E. .....Fountaintown
Miller, Frank H. .....Morristown
Patten, Vernon C. (H) .Morristown

Shelbyville

Barnum, Emerson..Methodist Bldg.
Billman, Gustus S. .....R. R. 2
Coomes, M. Joseph (H)
20 East Broadway
Dalton, Wilson L...401 W. Perkins
Gehres, Robert W..15 S. Tompkins
Inlow, H. H....103 W. Washington
Inlow, W. D....103 W. Washington
Miller, Richard C. .....17 Mechanic
Richard, N. F..103 W. Washington

SHELBY COUNTY

(Shelbyville—Continued)

Scott, V. B.....103 W. Washington
Silbert, David B.....Pitman Bldg.
Spindler, Robt. D..165 W. Mechanic
Tindall, Paul R.....20 N. Pike
Tindall, W. R. .... 505 S. Harrison
Whitcomb, Roger F.
302 Methodist Bldg.
Wiley, William M.....Shelbyville

Coulson, Sewell B. .....Waldron
Keeling, James E. (H) ....Waldron
Fodor, Oscar....5306 E. 180th St.,
Seattle 55, Wash.

SPENCER COUNTY

Barrow, John H. .....Dale
Medcalf, Norman L.....Lamar
Lomax, Claude C.....Lincoln City
Jolly, Wesley P. .....Richland
Atchison, Kenneth C.....Rockport
Ehrman, C. D. .....Rockport
Glackman, John C., Jr....Rockport
Kerrigan, William F.....Rockport
Buxton, Eva J. (H)
West Memphis, Ark.

STARKE COUNTY

Ferguson, John T. .....Hamlet
DeNaut, James F. .....Knox
Henry, Howard S. .....Knox
Ingwell, Guy B. .....Knox
Farabee, Charles R...North Judson
Matthew, J. R.....North Judson

STEUBEN COUNTY

Barton, Robert .....Angola
Creel, Donald W. .....Angola
Crum, Marion M.....Angola
Hartman, John J.....Angola
Kissinger, Knight L.....Angola
Lane, William H. (H).....Angola
Mason, Donald G.....Angola
Rausch, Norman W. .....Angola
Blosser, Blaine A. .....Fremont
Hippensteele, Ralph O....Fremont
Alford, James .....Hamilton
Denman, Robert D. (H)....Helmer

SULLIVAN COUNTY

Brown, John S. .....Carlisle
Whipps, Charles E.....Carlisle
Dukes, Betty .....Dugger
Dukes, Frederic M. .....Dugger
Dukes, Joe E. .....Dugger
Bland, Herbert E. (H)..Fairbanks
Bethea, Robert O.....Farmersburg
O'Dell, Harry C. .....Farmersburg
Oliphant, Jacob T....Farmersburg
Hamilton, Antha Ann....Shelburn
Bedwell, Marion H.....Sullivan
Briggs, Carl F. .....Sullivan
Crowder, James H., Jr.....Sullivan
Maple, James B. .....Sullivan
Scott, Garland D. .....Sullivan
Scott, Irvin H. .....Sullivan

SWITZERLAND COUNTY

Bear, Lowery H. (H).....Vevay
Copeland, Geo. W. (H).....Vevay
Ellerbrook, George E.....Vevay
Graves, Noel S.....Vevay
Griffith, Harold .....Vevay

TIPPECANOE COUNTY

Wagoner, John B. .....Colburn
Wagoner, Robert H. (H)..Colburn

Lafayette

Ade, C. H. ....Lafayette Life Bldg.
Ade, Mary K..Lafayette Life Bldg.
Arnett, Arett C.....312 N. Eighth
Balkema, C. M.
623 Lafayette Life Bldg.
Bauer, Arthur J....112 N. Seventh
Bayley, William E..Home Hospital
Beeler, James M.
Wabash Valley Sanitarium
Buhrmester, Harry C., Jr.
312 N. Eighth
Burkle, John C.....133 N. Fourth
Burns, Kendall R.
St. Elizabeth Hospital
Calvert, Raymond R...314 N. Sixth
Cole, Ira .....2315 South
Cox, Wayne T..206-7 Schultz Bldg.
Coyner, Alfred B.
815-16 Lafayette Life Bldg.
Crockett, Franklin S.
724 Lafayette Life Bldg.
Dewey, G. W. (H)..Soldiers Home
Donahue, George R.
Lafayette Life Bldg.
Dubois, Ramon B.....516 Main
Eaton, M. J..Lafayette Life Bldg.
Engeler, James E....308 N. Eighth
Ferguson, Wm. B....24 N. 24th St.
Flack, Russell A.....217 N. Sixth
Frasch, M. G..Lafayette Life Bldg.
Frey, Harley B.
405 Lafayette Life Bldg.
Gery, Richard E.....312 N. Eighth
Graham, T. G..11 N. Twenty-fourth
Harden, Murray
716 Lafayette Life Bldg.
Harshman, M. L.....312 N. Eighth
Harter, Eli Blair....312 N. Eighth
Herrold, George W.
2323 South St.
Holladay, Lloyd J.
Lafayette Life Bldg.
Hughes, Richard....2216 South St.
Hunsberger, W. G....506 S. 7th St.
Hunter, F. P..Lafayette Life Bldg.
Hupe, Charles (H)..212 N. Eighth
Ikins, Ray G.....605 S. Seventh
Johnson, Herbert S...312 N. 8th St.
Johnson, Lowell R.....2315 South
Jones, David..24 N. Twenty-fourth
Karberg, R. J...15 N. Twenty-fifth
Klepinger, Harry E.
824 Lafayette Life Bldg.
Laws, H. J....Lafayette Life Bldg.
Laws, Kenneth F.
501 Lafayette Life Bldg.
Loop, Floyd A.
Lafayette Life Bldg.
Loop, F. A....Lafayette Life Bldg.
McAdams, H. B...631 Columbia St.
McClelland, D. C.....312 N. Eighth
McFadden, James M.
St. Elizabeth Hosp.
McKinney, Daniel H.
Lafayette Life Bldg.
Marsh, G. W....1405 N. Fourteenth
Martin, H. G.....417 Ferry
Martin, Joe M. .....417 Ferry
Miller, Roland E.....1625 Kossuth
Morrison, John S. (H)
Lafayette Life Bldg.
Neumann, Kenneth O.
613 Lafayette Life Bldg.
Pearlman, Samuel S...107 N. Sixth
Peterson, Joel A.
609 Lafayette Life Bldg.
Peyton, Frank W.....15 N. 25th
Ratcliff, Frank W.....300 Main
Rothrock, Philip W...1625 Kossuth
Ruschli, Edward B.
Lafayette Life Bldg.
Shafer, John W. (H)..619 Kossuth
Sholty, William M.
405 Lafayette Life Bldg.
Smith, Lowell C..405 Schultz Bldg.
Stahl, Edward T.....312 N. Eighth
Strayer, Joseph W.
612 Lafayette Life Bldg.
Strickland, Martha B..114 Wells St.
Thomas, Gordon A...608 Columbia
Trout, Carl J.....314 N. Sixth
Tubbs, George R. (H)
608 Columbia
VanBuskirk, E. L....308 N. Eighth
Vermilya, Robert W.
Lafayette Life Bldg.
Waite, Richard R.....115 S. Sixth
Washburn, Will W...312 N. Eighth

Mitchell, Edgar T.....Romney
Babb, Forrest J. .....Stockwell

West Lafayette

Ash, Harold H.....200 South St.
Carroll, Bertha Rose
Purdue University
Mather, Robert L....254 Littleton
Meikle, Louise J...606 Ferry Lane
Miller, Sayers J.....Purdue Univ.
Romberger, Floyd T..424 Littleton
Rommel, C. H...460 Northwestern
Stapleton, Pauline
1520 Summit Drive
Spurlock, Fae H..214 Northwestern

Simpson, Gordon .....Halt-Krock
Clinic, Fort Smith, Ark.

TIPTON COUNTY

Cotton, Stanley M.....Goldsmith
Dunham, Wilbur F.....Kempton
Stouder, Albert E.....Kempton
Tranter, William F.....Sharpsville
Burkhardt, Boyd A. .....Tipton
Carter, Jean V. .....Tipton
Compton, George .....Tipton
Gossard, Meredith B.....Tipton
Kurtz, William A. .....Tipton
Overman, Frederick V.....Tipton
Warne, George H. .....Tipton
Ericson, Harold L. .....Windfall
Moser, Elmer B. .....Windfall

UNION COUNTY

(See Wayne-Union).

VANDERBURGH COUNTY

Evansville

A

Acre, Robert R. . 617 Hulman Bldg.
Adler, Raymond N. . . . . 714 Second
Alexander, John E.
609 Hulman Bldg.
Anderson, Dwight W. . . 814 N. Main
Antes, Earl H. . . . . 412 SE Fourth
Austin, E. W. . 216 SE Riverside Dr.

B

Baker, H. M. . . . . 402 Hulman Bldg.
Baker, Jas. S. . . 407 Metro Bk. Bldg.
Ballas, William A.
Deaconess Hospital
Barclay, Irvin C. . . . . 114 SE Second
Barnhart, Willard T. . 527 Sycamore
Baylor, Edward M. . . 415 S. Lincoln
Beck, Robert E. . . . . 600 Mary St.
Beeler, Bruce H.
709 S. Kentucky Ave.
Bennett, Abner
Welborn Baptist Hospital
Bissonnette, Roger P.
412 S.E. 4th St.
Boswell, R. W. C. . . . . 2509 Wash.
Boyd, Stella N. . . 502 Hulman Bldg.
Brockmole, A. W. . . . . 700 Mary St.
Brown, R. L. . . . . 629½ Main St.
Brown, J. A., Jr. . . . . 605 E. Sixth
Browne, W. A. . . . . 201 S.E. 3rd St.
Bryan, S. L. . . . . 607 Hulman Bldg.
Buchholz, R. R. . . . . 412 SE Fourth
Buehner, Donald F. . . . 600 Mary St.
Buikstra, C. R. . . 609 Hulman Bldg.
Burnikel, Ray H. . . . . 221 Chestnut

C

Cacia, John J. . . . 609 Hulman Bldg.
Caldwell, W. C. . . . 504 Old Nat. Bk.
Clements, Albert F. . . 15 SE Second
Clouse, Paul A.
613 S. Weinbach Ave.
Cockrum, W. M. . 908 Hulman Bldg.
Cody, Burtis L. . . 204 Boehne Bldg.
Coleman, Joseph E.
216 SE Riverside Dr.
Combs, H. T. . . . . 807 W. Indiana
Combs, Jno. H. . . . . 412 SE Fourth
Combs, Pearl B. . . . . 1623 Lincoln
Corcoran, P. J. V. . . . . 118 S. First
Crawford, Jas. H. . . . . 221 Chestnut
Crevello, Albert J.
Clearview Hosp., Kratzville Rd.
Crimm, Paul D. . . . . Boehne Hosp.
Cullnane, C. W. . . 2312 W. Franklin

D

Daves, William L.
608 Old Nat. Bk. Bldg.
Denzer, Edw. K. . . . . 108 SE Second
Denzer, Wm. O. . . . . 108 SE Second
Dieckman, H. S. 1012 Cit. Bk. Bldg.
Diefendorf, Charles F. (H)
2106B W. Franklin
Dodd, Roberts K. . . 819 W. Franklin
Durkee, Melvin S.
403 Citizens Nat. Bk. Bldg.
Dycus, Walter A.
319 N. St. Joseph Ave.
Dyer, W. K. . . . . 221 Chestnut St.

E

Ehrich, William S.
808 Old Nat. Bk. Bldg.
Eisterhold, J. A. . . 220 SE Riverside
Engel, Edgar L. . . . . 15 SE Seventh

F

Faul, Henry J. . . 815 Hulman Bldg.
Fickas, Dallas . . . . . 619 Mary St.
Fisher, Wm. C. . . . . 413 First Ave.
Fitz Gerald, Maurice D.
St. Mary's Hospital
Fitzsimmons, E. L. . . 527 Sycamore
Flinn, J. H. . . . . 221 Chestnut St.
French, Wm. G. . . . Sta. D, Box 2006
Friedman, Leo . . . . . 9 Main
Fritsch, Louis E. . . . . 1201 First

G

Gaard, Richard C.
5118 Washington Ave.
Garland, Edgar A. . 606 S. Weinbach
Gaul, L. Edw. . . . 509 Hulman Bldg.
Gill, Bernard P. . . . 113½ NW Fifth
Grant, John H. . . . 957 S. Kentucky
Griep, Arthur H. . . . 412 SE Fourth

H

Hammond, R. Case
221 Chestnut St.
Hare, Daniel M. . 617 Hulman Bldg.
Hare, John H. . Evansville St. Hosp.
Harris, Wm. Lee . . . . 115 SE 6th St.
Hartley, C. A., Jr. . . . . 221 Chestnut
Hartz, F. Minton . . . . 123 SE Second
Heard, Albert . . . . . 322 E. Cherry
Heberer, Jos. M. . 1111 W. Columbia
Hefti, Karl R. . . . . 125 SE Second
Heinrich, Weston A. . . 1308 N. Main
Herrman, Gordon T.
402 Hulman Bldg.
Herzer, Clarence C. . . 322 N. Fulton
Hobbs, Arthur . . . . . 600 Mary St.
Hoopes, Jane M. . . . . 125 SE Second
Huggins, Victor S.
601 Citizens Nat. Bk. Bldg.
Hyatt, Gilbert T. . . . 412 SE Fourth

J

Johnson, G. C. (H)
212 Indiana Bank Bldg.
Johnson, Stephen L. . . 521 Sycamore

K

Kauffman, Harley M. . . 219 Walnut
Kessler, Robt. B. . . 1338 Division St.
Kiechle, F. L. . . . . Boehne Hosp.
Kirch, Leo N. . . 912 Hulman Bldg.
Kleindorfer, R. L. . 819 W. Franklin

L

Lang, Shirley C. . . 957 S. Kentucky
Laubscher, Clarence . Kratzville Rd.
Lawrence, Jos. C. . . . 413 First Ave.
Leich, Chas. F. . . . . 124 SE First
Leslie, Ermil T. . . . . 122 Locust
Logan, Jesse R. . . . . 503 First Ave.
Lynch, Harold D. . 216 SE Riverside
Lynch, Paul V.
Evansville State Hosp.

M

McCool, Joe H. . . . . 1308 N. Main
McCool, William E. (H)
R. R. 5, Camp Ground Rd.
Macer, C. G. . . . . 411 Hulman Bldg.
MacKenzie, Pierce . . 15 SE Seventh
Mason, E. E. . . . . 906 Hulman Bldg.
Mehl, Rudolph A. . . . . 752 S. Eighth
Meyer, Keith T. . . . . 118 SE First
Miller, Laverne B. . . . . 714 N. Main
Miller, Milton . . . . . 103 N. Main
Miller, Minor . . . . Court Hse. Annex
Miller, Robert J. . . . . 1905 Division
Mills, Fred E. . . . . Deaconess Hosp.
Mino, Raymond W. . . . 600 Mary St.
Mino, Victor H. . . . . 723 Mary
Moehlenkamp, Charles E.
614 N. Governor
Muelchi, A. F. . . . 518 Hulman Bldg.
Murphy, Edw. U.
908 Hulman Bldg.

N

Nenneker, Henry (H)
Harmonyway
Neucks, H. C. . . . . 207 SE First St.
Newman, A. E. . 912 Hulman Bldg.
Niedermayer, Alfred J.
960 Washington Ave.
Nisenbaum, Harold
704 Hulman Bldg.
Nonte, Leo R. . 1651-B Lincoln Ave.

O

Oppenheimer, Ernst . 103 SE Second
Oswald, Robert
840 Bayard Park Dr.

P

Pastor, Julius W. . . . . 5206 Lincoln
Pollard, Walter S. . . 115 SE Second
Porro, Francis W. . St. Marys Hosp.
Present, Julian . . . 113 S.E. Second
Price, Shirley G. . . . 412 S.E. 4th St.
Pugh, Willis . . . . . 413 First

R

Raphael, I. J. . . . . 617 Hulman Bldg.
Ratcliffe, A. W. . . . . 510 SE First
Ravdin, B. D. . . . . 712 Hulman Bldg.
Reich, Clarence E. . . 1209 N. Fulton
Reitz, Thos. F. . . . . 700 N. Sixth
Rininger, H. C. . . . 1359 Washington
Ritz, Albert S. . . . . 2605 Lincoln
Ritchie, William D.
608 Old Nat'l Bank Bldg.
Robinson, Earle U. . 615 Bellemeade
Rosenblatt, B. B. . 709 Hulman Bldg.
Rossow, Russell . . . . . 118 SE First
Royster, G. M. . . . 810 Cit. Bk. Bldg.
Royster, R. A. . . . 810 Cit. Bk. Bldg.
Ruddick, H. C. . . 816 Hulman Bldg.
Rusche, Henry J. . . . . 313 W. Iowa
Russell, Richard H.
St. Mary's Hospital

S

Schaefer, William C.
St. Mary's Hospital
Schirmer, R. H. . . 1118 W. Franklin
Schneider, Charles P.
2211 W. Franklin St.
Schriefer, Victor V.
420 N. Main St.
Slaughter, H. C. . 908 Hulman Bldg.
Slaughter, John . . 821 Cit. Bk. Bldg.
Slaughter, O. L. . . . . 118 E. First
Snively, W. D., Jr.
Mead Johnson & Co.
Springstun, Walter R.
601 Hulman Bldg.
Steele, Paul W. . . . . 629½ Main St.
Sterne, John . . . . 308 Wright Bldg.
Stork, Urban . . . . . 412 SE Fourth
Sutter, Chas. C.
Evansville State Hosp.

VANDERBURGH COUNTY

(Evansville—Continued)

T

Taylor, Eugene C.....853 Lincoln
Tilden, Margaret.200 S. Parker Dr.
Tweedall, D. C....527 Sycamore St.
Tweedall, D. G...2114 W. Franklin

U-V

Underwood, Gordon B.
509 Hulman Bldg.
Viehe, Robt. W.....207 SE First
Visher, John W.
805 Old Nat. Bk. Bldg.

W

Weber, Edgar H....123 SE Second
Weiss, Henry G..614 Hulman Bldg.
Welborn, Mell B....412 SE Fourth
Wesson, Thos. W.....124 SE First
Wilhelmus, C. Kenneth
115 SE 7th St.
Wilhelmus, Gilbert.....1028 Wash.
Wilhelmus, Wm. M.....R. R. 7
Willis, Chas. F.....1100 S. Bedford
Willison, G. W.....118 SE First
Wilson, J. D. ...517 Sycamore St.
Wilson, Ralph .....517 Mary
Wishart, Shelby W.
416 3rd & Main Bldg.
Wood, Wm. H....1651½ Lincoln Av.
Woods, Wm. P.....15 SE Seventh
Wynn, J. F.....906 Hulman Bldg.

X-Y-Z

Yeck, Charles W.....115 SE Sixth
Young, C. Curtis...12 S.E. 7th St.
Yunker, Philip E.....116 Mulberry
Zimmerman, Harold..6 SE Second

Coffman, Delmer Lee
Western Okla. T. B. Hosp.,
Clinton, Okla.
Hart, L. Paul....1454 Coolidge Dr.,
University City, Mo.
McDonald, Jos. D....1463 Coolidge,
University City, Mo.
Visher, John S.....2139 Hoyt,
Univ. Grove E., St. Paul, Minn.
Wyatt, Fred H....1301 Garfield St.,
Denver, Colo.

VERMILLION COUNTY

(See Parke-Vermillion)

VIGO COUNTY

Loving, Jury B.....New Goshen
McIntosh, Wilbert .....Riley
Carmichael, Clyde S.....Seelyville

Terre Haute

A

Agee, Ernest B., Jr....221 S. Sixth
Alexander, Oliver O.
301 Rose Disp. Bldg.
Allen, O. T....422 Rose Disp. Bldg.
Anderson, W. C.....721 Wabash
Asbury, W. D. (H)
322 Rose Disp. Bldg.
Ault, Roy.....Tribune Bldg.

B

Baldridge, William O.
12 Points State Bk. Bldg.
Blum, Leon L.
210 Rose Dispensary Bldg.
Bopp, Henry W.
521 Grand Opera Hse. Blg.
Bopp, James.....521 Opera Bldg.
Bradley, Stephen C..916 S. 25th St.
Bronson, Paul J.....721 Wabash
Brown, Robert R.....221 S. Sixth

C

Cajacob, Melville E...1000 S. Sixth
Carpenter, George C.....410 Ohio
Cavins, Alexander W..221 S. Sixth
Combs, Chas. N.....2516 N. Ninth
Combs, S. R.....505 Tribune Bldg.
Congleton, George C.
308 Merchants Nat. Bk. Bldg.
Conklin, J. O..500 Rose Disp. Bldg.
Crawford, William G.
221 S. Sixth St.
Curry, C. A...506 Rose Disp. Bldg.

D

Decker, Harvey B....202 Rea Bldg.
Dorsey, Philip W....Tribune Bldg.
Dyer, Geo. W..208 Rose Disp. Bldg.

E

Edmondson, R. E.....720 Collett
Eisenlohr, Eugen .....128 S. Sixth

F

Forsyth, David H.
215 Merchants Nat. Bk. Bldg.
Freed, J. E...414 Rose Disp. Bldg.
Freed, John E., Jr.
414 Rose Disp. Bldg.
Fuqua, H. B.....Rose Disp. Bldg.

G

Gerrish, D. A.....Rose Disp. Bldg.
Gilbert, Ivan 505 Rose Disp. Bldg.
Gillum, John R.....221 S. Sixth
Goodman, Hubert T.
310 Opera House Bldg.
Gossom, Donn R...Rose Disp. Bldg.

H

Harkness, Robert G.
301 Rose Disp. Bldg.
Haslem, E. R..401 Rose Disp. Bldg.
Haslem, John R.....221 S. Sixth
Hoover, Dewey A. ...14½ N. Third
Hoover, Jas. J.....14½ N. Third
Humphrey, Paul E.
322 Rose Disp. Bldg.
Hunt, Edgar J.....R. R. 1

J

Johnson, Paul D...221 S. Sixth St.

K

Kabel, Robert N.....Tribune Bldg.
Krieble, William W....221 S. Sixth
Kunkler, Joseph .....408 Chestnut
Kunkler, William C.
212 Merchants Bk. Bldg.

L

LaBier, Clarence Rollin (H)
1630 Wabash Ave.
LaBier, C. R...1630 Wabash Ave.
Lancet, Robert O.....2022 Wabash
Lee, Allen H.....502 Tribune Bldg.
Loewenstein, W. L..1421 S. Seventh
Love, John R.....1601 Eighth Ave.
Luckett, C. L..211 Fairbanks Bldg.

M

McBride, Noel S.
407 Merchants Nat. Bk. Bldg.
McCormick, Wilbur C.
312 Merchants Bk. Bldg.
McEwen, James W.
321 Rose Disp. Bldg.
McLaughlin, Gordon C.
501 Tribune Bldg.
Mahoney, Charles L...221 S. Sixth
Malone, Leander A.....721 Wabash
Mason, Lester M.
312 Merchants Nat. Bk. Bldg.
Mattox, Don M.....721 Wabash
Meyn, Werner P.....221 S. Sixth
Miklozek, John E..1461 S. Seventh
Miller, Daniel B....1603 S. Seventh
Mitchell, A. M...503 Tribune Bldg.
Mohr, Ann L. M.....R. R. 1,
West Terre Haute
Musselman, G. G..424 Fourth Ave.

N-O

Nay, Ernest O.....221 S. Sixth
Neudorff, Louis G..221 S. Sixth St.
Oliphant, R. W..410 Tribune Bldg.

P

Pearce, Roy V.....1440 S. 25th St.
Pierce, Harold J.....627 Cherry

R

Reed, Robert C..211 Fairbanks Bld.
Reynolds, Richard J....901 S. 25th
Richart, J. V..414 Rose Disp. Bldg.
Riggs, Floyd C.
Indiana State Teachers College
Rubin, Milton M.....Tribune Bldg.

S

Sayers, F. E.....R.R. 5, Box 39A
Scherb, Burton E...104 N. Seventh
Schott, Edward J. (H)
Merchants Nat. Bk. Bldg.
Schumaker, Robert A.
211 Fairbanks Bldg.
Selsam, Etta
203 Merchants Nat. Bk. Bldg.
Shanklin, Vernon A.
202 Fairbanks Bldg.
Showalter, J. R....1255½ Maple Rd.
Siebenmorgen, L....1200 S. Eighth
Siebenmorgen, P....1200 S. Eighth
Siegman, Edwin L.....627 Cherry
Silverman, N. M...1634 S. Seventh
Sloss, Imit H.....1029 S. Seventh
Smoots, S. A.....1307 Maple Ave.
Solomon, Robert D.
721 Wabash Ave.
Speas, R. C.....402 Tribune Bldg.
Spigler, James F.
314 Merchants Nat. Bk. Bldg.
Stewart, Walter E.....721 Wabash
Stoelting, J. L.507 Rose Disp. Bldg.
Strecker, Wm. L.....2250 Wabash
Strong, Daniel S....R.R. 7, Box 170
Sullivan, John M.
1712 Franklin St.

VIGO COUNTY

(Terre Haute—Continued)

T

Topping, M. C...505 Tribune Bldg.

U-V

Utterback, Arnold
214 Merchants Nat. Bk. Bldg.
VanArsdall, C. R.....17 S. Ninth
Voges, Edward C.....1402 Wabash

W

Weber, Joseph G. S....721 Wabash
Weinstein, Joseph H...221 S. Sixth
White, Jas. V.....Tribune Bldg.
Wiedemann, Frank E. (H)
222 Rose Disp. Bldg.
Wilkerson, Edw. L....6½ N. Fourth
Wilson, Fred L.....1501 S. Third
Wyeth, Chas. (H).1100 S. Seventh

X-Y-Z

Yung, J. R....501 Rose Disp. Bldg.
Zwerner, Paul F.
12 Points State Bk. Bldg.

Day, Theodore P..832 Waverly Rd., Willoughby, Ohio

WABASH COUNTY

Walker, James L.....LaFontaine
Balsbaugh, Geo.....N. Manchester
Brubaker, O. G. (H)
N. Manchester
Bunker, L. Z.....N. Manchester
Cook, Chas. E.....N. Manchester
Seward, Geo. W.....N. Manchester
Venable, Geo. L.....N. Manchester
Warvel, Joseph L. (H)
N. Manchester
Kidd, James G.....Roann
Black, Edgar K.....Wabash
Dannacher, Wm. D.....Wabash
LaSalle, Robert M.....Wabash
Mills, John F.....Wabash
Naugle, Raymond A.....Wabash
Pearson, William E.....Wabash
Rhamy, Arthur P.....Wabash
Steffen, Arthur J.....Wabash
Steffen, Julius T.....Wabash
Stoops, Jean T.....Wabash
Whisler, Frederick M.....Wabash
Thompson, Noah H. (H)
Elks Home, Bedford, Va.
Wall, Joseph A....Owensboro, Ky.

WARREN COUNTY

(See Fountain-Warren)

WARRICK COUNTY

Hoover, Peter B.....Boonville
Purcell, Jack H.....Boonville
Samples, John T.....Boonville
Stover, Wendell C.....Boonville
Wilson, Paul E.....Boonville
Taylor, Lon S.....Elberfeld
Faith, Ira L.....Newburgh
Wilhelmus, Charles M...Newburgh
Springstun, Charles E....Tennyson
Hoover, J. Guy.....VA Hospital, Minneapolis, Minn.
Zwickel, Ralph E.
1782 Wilton Rd., Cleveland, Ohio

WASHINGTON COUNTY

Tower, Thomas K...Campbellsburg
Green, William L. (H).....Pekin
Episcopo, A. R.....Salem
Gilliatt, James P.....Salem
Huckleberry, Irvin E.....Salem
Mull, Philip L. (H)
Bluegrass Hotel, Louisville, Ky.

WAYNE-UNION COUNTIES

Clark, Marion E...Cambridge City
Hill, Paul G.....Cambridge City
Kenyon, Charles E.Cambridge City
Barton, Willoughby M..Centerville
Hutchison, Donald R.Fountain City
McKee, Charles E. (H).....Dublin
Zimmerman, Wm. H.....Dublin
Marsh, Chester A.....Hagerstown
Miller, William A.....Hagerstown
Shively, John L.....Hagerstown
Dubois, Franklin T. (H)...Liberty
Lewis, James F.....Liberty
McWilliams, William B....Liberty
Thompson, Will A.....Liberty
Denny, Edgar C.....Milton

Richmond

Adney, Frank B.
306 Medical Arts Bldg.
Ake, Loren
410 First Nat. Bk. Bldg.
Allen, Hubert E.....21 S. Eighth
Allen, Robert T.....21 S. Eighth
Ballenger, William E.
309 Med. Arts Bldg.
Blossom, Paul W.....825 S. A St.
Bond, Charles S. (H).110 N. Tenth
Buche, Fredk. P.....106 S. Seventh
Campbell, Perry A.
422 Med. Arts Bldg.
Coble, Frank H.....51 S. Eighth
Cook, Norman R.
508 First Nat. Bk. Bldg.
Cox, Leon T.....36 S. Eighth
Daubenheyer, M. F. Rich. St. Hosp.
Dingle, P. E..403 Med. Arts Bldg.
Ebbinghouse, Tom.....98 W. Main
Ewbank, J. Nelson
Smith-Esteb Hosp.
Griffis, V. C...208 Med. Arts Bldg.
Hadley, Harvey..1st Nat. Bk. Bldg.
Hagie, Franklin E.
302 Second Nat. Bk. Bldg.
Harmon, C. J. 407 Med. Arts Bldg.
Harmon, G. H..407 Med. Arts Bldg.
Hays, George R.
401 Second Nat. Bk. Bldg.
Hill, H. D.....412 Med. Arts Bldg.
Hoffman, Curtis R.
405 First Nat. Bk. Bldg.
Hunt, G. J...Reid Memorial Hosp.
Johnson, George M.
201 First Fed. Bldg.
Johnson, P. S..215 Med. Arts Bldg.
Kime, Charles E.....810 S. A St.
Krueger, Fredk. W...45 S. Seventh
Laird, Leslie A.....Rich. St. Hosp.
Lee, G. W.....139 Med. Arts Bldg.
Ling, John F...306 Med. Arts Bldg.
Logan, James Z.
203 Second Nat. Bk. Bldg.
Mader, John H.....808 South A
Malcolm, R...127 Med. Arts Bldg.
Meredith, Elwood J.
203 Med. Arts Bldg.
Ross, Harry P.
410 Second Nat. Bk. Bldg.
Ross, James S...302 Colonial Bldg.
Ross, Louis F.
308 Second Nat. Bk. Bldg.
Runge, Paul W.....1426 E. Main
Sage, Charles V.....48 S. Eleventh
Shields Tom S.....47 S. Eleventh
Smith, John R.....510 S. A St.
Snyder, M. C..130 Med. Arts Bldg.
Stamper, L. A..402 Med. Arts Bldg.
Stepleton, J. D...Reid Mem. Hosp.
Sweet, H. E.....35 S. 8th St.
Taylor, W .R...308 Med. Arts Bldg.
Vance, W. C...136 Med. Arts Bldg.
Wanninger, Horace
408 Second Nat. Bk. Bldg.
Warrick, Francis B...1426 E. Main
Weinstein, E. B..204 Colonial Bldg.
Wertenberger, Morris D.
Reid Mem. Hosp.
Whallon, Arthur J.....29 S. Tenth
Williams, Paul D...Rich. St. Hosp.
Wisener, G. H..213 Med. Arts Bldg.
Yencer, Martin W. (H)..22 N. 14th

Faulkner, W. H.
Meharry Med. Col., Nashville, Tenn.
Land, Richard N.
Herman Hosp., Houston, Tex.
Pentecost, Paul....Charity Hosp., New Orleans, La.
Heck, Rolfe A...College Corner, O.
Shepard, Fred F.
College Corner, Ohio

WELLS COUNTY

Bluffton

Annis, Homer B.....303 S. Main
Aucreman, Charles J...303 S. Main
Banker, Harry W...303 S. Main St.
Brickley, Harry D.....227 S. Main
Brickley, Richard A....227 S. Main
Buckner, Joy F. 116 E. Walnut St.
Caylor, Harold D.....303 S. Main
Caylor, T. E.....303 S. Main
Cook, Robert G.....303 S. Main
Dorrance, Thos. O.....303 S. Main
Eisaman, Jack L.....303 S. Main
Gillette, Walter R..303 S. Main St.
Gitlin, Max M.....121½ E. Market
Gitlin, William A....121 E. Market
Hamilton, O. G.....227 S. Main
Johnston, Robert L.....303 S. Main
Mead, Clarence H.....227 S. Main
Mitchell, George S..303 S. Main St.
Nickel, Allen.....303 S. Main
Tirman, Wallace S.....303 S. Main
Yoder, Richard P.....303 S. Main

Gingerick, C. M.....Liberty Center
Davidoff, Manuel A.....Ossian
Hardin, Wayne E.....Ossian
Lloyd, John T.....Louisburg, N.C.
Sherman, Robert M...Christ Hosp., Cincinnati, Ohio
Talbert, Pierre C.
4106 Locust St., Philadelphia, Pa.

WHITE COUNTY

Galbreth, Jesse P.....Burnettsville
Derhammer, George L...Brookston
Gish, Howard M.....Brookston
Netherton, Clyde R.....Chalmers
Houser, Wayne W.....Monon
McClure, Stanley E.....Monon

WHITE COUNTY
(Continued)

Carney, John C.....Monticello
Gable, Homer B.....Monticello
Greist, H. W. (H).....Monticello
Hibner, Nolan .....Monticello
Morris, Warren V.....Monticello
Mayfield, Clifford H.....Reynolds
Forbes, Violet M. Crabbe..Wolcott

WHITLEY COUNTY

Briggs, Jesse H.....Churubusco
Hershey, Ernest A.....Churubusco
Heritier, Claude J...Columbia City
Kratz, Paul E.....Columbia City
Langohr, John.....Columbia City
Lehmberg, Otto F...Columbia City
Nolt, Ernest V.....Columbia City
Pence, Benjamin F..Columbia City
Thompson, Frank...Columbia City
Garber, Paul A.....South Whitley
Huffman, Verlin P...South Whitley

MEMBERS OF WOMAN'S AUXILIARY

BY COUNTIES

ADAMS COUNTY

Berne

Beaver, Mrs. N. E..365 N. Harrison
Habegger, Mrs. M. L.....505 Clark
Lehman, Mrs. Harold B.
Franklin St.
Reusser, Mrs. Amos..256 Sprunger

Decatur

Burk, Mrs. J. M.....221 S. Third
Carroll, Mrs. J. C.....R. R. 4
Duke, Mrs. B. E.....145½ S. Second
Girod, Mrs. A. H...1004 W. Monroe
Kohne, Mrs. G. J.....304 W. Adams
Parrish, Mrs. Richard.238 S. Second
Rayl, Mrs. C. C.....334 S. First
Reppert, Mrs. R. L...Road No. 224
Smith, Mrs. W. E.....116 S. Third
Terveer, Mrs. John.415 W. Madison
Zwick, Mrs. H. F.....401 E. Rugg

Geneva

Schetgen, Mrs. J. V.....Box 236

ALLEN COUNTY

Bluffton

Brickley, Mrs. H. D....227 S. Main
Buckner, Mrs. J.....116 E. Walnut
Hamilton, Mrs. O. G..203 E. Central
Mead, Mrs. C. H.....211 W. Wash.
Morris, Mrs. G. B...116 W. Market

Fort Wayne

A

Adams, Mrs. J. R.....621 W. Berry
Aiken, Mrs. A. F.....1927 E. State
Aiken, Mrs. N. E.....1923 E. State
Aldrich, Mrs. Harry.2710 Broadway

B

Bailey, Mrs. Paul..1840 Pemberton
Baltes, Mrs. Joseph...4816 Beaver
Bash, Mrs. W. E.....4626 Stratford
Beams, Mrs. Ralph 1801 California
Beierlein, Mrs. Karl...Butler Road
Berghoff, Mrs. Raymond
2009 Forest Park
Blosser, Mrs. H. V..1122 W. Wash.
Bolman, Mrs. Morton
1038 Maxine Dr.
Bowers, Mrs. G. T...2609 E. Drive
Bowers, Mrs. J. W....817 E. Wash.
Brosius, Mrs. Robt.....1530 Lake
Brown, Mrs. Frederic
906 Woodview
Bruggeman, Mrs. H. O.
1202 W. Wash.
Bryan, Mrs. Frank.1439 Edgewater
Buckner, Mrs. Doster.....Bass Rd.
Bulson, Mrs. Eugene
4301 Pembroke Lane

C

Calvin, Dr. Jessie...312 W. Wayne
Cameron, Mrs. D. F.2724 N. Clinton
Carlo, Mrs. E. R...4633 Crestwood
Cartwright, Mrs. E. L..529 Packard
Catlett, Mrs. M. B....1143 Rudisill
Clark, Mrs. W. R..4002 S. Harrison
Cooney, Mrs. C. J...1168 Westover
Cowan, Mrs. J. C..Lincoln Hwy. E.
Craig, Mrs. Richard...4315 Beaver
Culp, Mrs. J. E.....1216 Illsley

D

Dancer, Mrs. C. R....905 Columbia
Datzman, Mrs. Richard C.
1405 Pemberton Dr.
Dunstone, Mrs. H. C..4134 Indiana

E

English, Mrs. C. H....2509 Webster
Estlick, Mrs. Richard..4223 Beaver

F

Ferguson, Mrs. A. N.
2015 Pemberton
Foy, Mrs. H. W....1816 Forest Pk.
Fichman, Mrs. A. M..323 W. Berry

G

Garton, Mrs. H. W.
Hamilton Rd., R. R. 6
Gerding, Mrs. Wm....2943 Central
Glock, Mrs. Maurice...1913 Forest
Glock, Mrs. W. R.921 Lexington Ct.
Graham, Mrs. G. M..3813 Hiawatha

H

Haffner, Mrs .Herman
3606 Mulberry Rd.
Hamilton, Mrs. Emory
2405 Florida Dr.
Harshman, Mrs. L. P.
2704 N. Clinton
Harvey, Mrs. H. C...2228 Crescent
Hasewinkle, Mrs. A. M.
1807 E. Rudisill
Hastings, Mrs. W. C. 1725 Huffman
Hattendorf, Mrs. A. P.
4041 Old Mill Rd.
Havens, Mrs. Russell
1845 Kensington
Hoffman, Mrs. S. P.
234 E. Maple Grove
Hoffman, Mrs. Arthur.4223 Indiana
Holsinger, Mrs. R. E..4617 Indiana
Horton, Mrs. G. R.
122 Sherwood Ter.
Howe, Mrs. F. L.....3714 Reed

J-K

Jackson, Mrs. John F.
617 Forest Ave.
Jurgenson, Mrs. Walter
454 Arcadia Ct.
Kent, Mrs. Richard..2717 E. Drive
Kidder, Mrs. O. T.
Irene Byron San.
Kissinger, Mrs. Chas. C.
Veterans Hosp.
Kruse, Mrs. E. H..2500 Randall Rd.

L

Ladig, Mrs. D. S....1014 Rivermet
Lehner, Mrs. John.1119 Maxine Dr.
Leming, Mrs. Ben L.
3005 N. Anthony
Lenk, Mrs. George
E. State Ext., R. R. 9
Lill, Mrs. J. C. .....4221 Buell Dr.
Lohman, Mrs. Robert.2138 Owaissa
Lloyd, Mrs. Robert.3609 S. Anthony
Loudermilk, Mrs. J. L.
1723 Pemberton

M

Mackel, Mrs. F. O.....708 Philey
McArdle, Mrs. E. G.
1133 W. Rudisill
McBride, Mrs. W. O.
610 Beechwood Circle
McCallister, Mrs. John W.
4215 Drury Lane
McDowell, Mrs. G .A.
2322 Forest Pk.
McEachern, Mrs. C. G.
4705 Indiana
McFall, Mrs. J. S.....3322 Garland
McKeeman, Mrs. Donald
1615 Ardmore
McNairy, Mrs. D. J....4522 Beaver
Mendenhall, Mrs. E. N.
232 S. Cornell Circle
Mercer, Mrs. S. R.
3235 N. Wash. Rd.
Meyer, Mrs. T. O....4438 Wilmette
Michaelis, Mrs. S. C.
1255 Korte Lane
Miller, Mrs. C. G...457 W. Oakdale
Miller, Mrs. H. P...417 W. Pontiac
Miller, Mrs. Mahlon....1115 Illsley
Miller, Mrs. O. J...1102 Kensington
Miller, Mrs. R. H...1322 W. Foster
Miller, Mrs. W. J.....310 E. Wash.
Moats, Mrs. Carl...4709 Arlington
Moats, Mrs. Geo...2107 Kensington
Moravec, Mrs. Arthur
4711 Old Mill Rd.
Mortensen, Mrs. Leland
1310 W. Foster Pkwy.

ALLEN COUNTY

(Fort Wayne—Continued)

Mueller, Mrs. Lawrence
3423 S. Wash. Rd.
Murdock, Mrs. H. L.
1212 Kensington

N-O

Nahrwold, Mrs. E. W.
3314 Irvington
Nill, Mrs. John....1116 Charlotte
O'Rourke, Mrs. Carroll
604 W. Berry
Oyer, Mrs. J. R...2206 Wawonaissa

P

Painter, Mrs. Donald
Wash. Center Rd.
Parker, Mrs. C. B....4520 Beaver
Perrin, Mrs. Kermit.Maysville Rd.
Perry, Mrs. Fredk....709 Kinnaird
Phillips, Mrs. John
37 Anthony Wayne Village
Popp, Mrs. Milton....3148 Parnell
Prentiss, Mrs. Nelson
919 Parkview Dr.

R

Ranke, Mrs. Henry....3112 Beaver
Ray, Mrs. Herbert
325 E. Creighton
Rhamy, Mrs. B. W....3452 Portage
Rice, Mrs. W. B....1023 Kinnaird
Rissing, Mrs. Walter
3200 Irvington
Rockey, Mrs. N. A.2411 Florida Dr.
Rodriguez, Mrs. Juan
4720 Crestwood Dr.
Roser, Mrs. Arthur...Leesburg Rd.
Rossiter, Mrs. D. L.724 W. Oakdale
Rothberg, Mrs. Maurice
4801 Tacoma
Rothchild, Mrs. Chas. J.
3015 N. Anthony

S

Salon, Mrs. Harry...2423 Fairfield
Salon, Mrs. Nathan..1024 Kinnaird
Savage, Mrs. Arthur.1602 Fairhill
Schafer, Mrs. D. W., Jr.
4010 Wawonaissa
Schlademan, Mrs. K. R.
4029 Weissei Park
Schlegel, Mrs. E. H.
2219 N. Anthony
Schmidt, Mrs. Eugene E.
1845 Forest Pk. Blvd.
Schmoll, Mrs. R. J....2129 Owaissa
Schneider, Mrs. L. A.
4621 S. Park Dr.
Scoins, Mrs. W. H..Taylor Rr., R. 8
Scott, Mrs. H. V.....5224 Fairfield
Shinabery, Mrs. Lawerence
1850 Broadway
Singer, Mrs. Elmer...825 Oakdale
Smith, Mrs. P. L. 3008 S. Lafayette
Somers, Mrs. Gerald
227 W. Fleming
Stauffer, Mrs. Richard
2116 Wawonaissa
Stellner, Mrs. Howard
4314 S. Calhoun
Stier, Mrs. Paul.....3807 Fairfield

T-V

Tennant, Mrs. David 5021 Fairfield
Terrill, Mrs. Richard
4120 S. Harrison
Thornton, Mrs. W. E.
601 W. Oakdale
VanBuskirk, Mrs. E. M.
920 Maxine Dr.

W

Wallace, Mrs. J. C.
4003 S. Harrison
Warfield, Mrs. C. H.
1809 Kensington
Welty, Mrs. S. G...509 W. Oakdale
Weber, Mrs. J. R....1215 Sheridan
Wilkins, Mrs. Robert
4839 Old Mill Rd.
Williams, Dr. Berniece
3526 N. Wash. Rd.
Wilson, Mrs. Leslie.2810 S. Wayne
Wright, Mrs. Wm. C.
1834 Pemberton
Wyatt, Mrs. J. L., Jr.
3401 N. Wash. Rd.

Z

Zehr, Mrs. Noah.301 W. Creighton
Zweig, Mrs. Elmer...3365 Garland
Dahling, Mrs. C. W.
1206 Powers St., New Haven
Emenhiser, Mrs. D. C.
1040 Lincoln Hwy., New Haven
Hoetzer, Mrs. E. M..Briar Hill, R. 2
Smith, Mrs. G. A.
Lincoln Hwy., New Haven
De Voe, Mrs. Kenneth...Woodburn

BARTHOLOMEW COUNTY

Columbus

Adler, Mrs. D. L....931 Fifth St.
Beggs, Mrs. L. F....2733 Riverside
Carpenter, Mrs. T. D..2328 Gilmore
Dagley, Mrs. Hubert R.
1103 California
Davis, Mrs. M. R...2228 Lafayette
Fisher, Mrs. W. S.....906 Franklin
Hart, Mrs. R. B.....1203 Sixteenth
Hawes, Mrs. M. E...N. Washington
Henry, Mrs. Alvin
Kincaid, Mrs. J. C..4 Mile Hse. Rd.
Macy, Mrs. George.....2603 Wash.
Marr, Mrs. Griffith.....1513 17th
Norton, Mrs. H. J.....909 Pearl
O'Bryan, Mrs. R. B.....1602 Wash.
Overshiner, Mrs. Lyman
1715 Franklin
Ritteman, Mrs. G. W...Caldwell Dd.
Ryan, Mrs. W. J.....2244 Pearl
Schmitt, Mrs. R. K.
2639 Riverside Dr.
Williams, Mrs. E. W..1902 Franklin
Wissman, Mrs. Wm. L.
1930 Lafayette
Yoder, Mrs. D. D.....713 Lafayette
Zaring, Mrs. B. K...2419 Riverside

Dudding, Mrs. Jos. E.....Hope
Schneider, Mrs. Kenneth.Nashville

BENTON COUNTY

Taylor, Mrs. W. H. .....Ambia
Atkinson, Mrs. C. W.....Boswell
Leak, Mrs. Robt.....Boswell
Turley, Mrs. Verne L.....Fowler
Altier, Mrs. Wm. H.....Fowler
Smith, Mrs. Chas. G.....Otterbein
Parker, Mrs. E. E.....Oxford
Scheurich, Mrs. Virgil.....Oxford

BOONE COUNTY

Schaaf, Mrs. Alvin....Jamestown

Lebanon

Ballard, Mrs. Robert
Country Club Park
Coons, Mrs. John.Country Club Pk.
Coons, Mrs. Ritchie 1617 Park Dr.
Headley, Mrs. Lloyd
Country Club Pk.
Honan, Mrs. Paul.Elmwood Addn.
Kern, Mrs. Clarence...423 E. Main
Spieth, Mrs. William
Country Club Pk.
Weddle, Mrs. Chas...1210 N. East
Wiseheart, Mrs. Robert
Country Club Pk.

Gregg, Mrs. Edwin.....Thorntown
Lovett, Mrs. Harvey..Whitestown
Bailey, Mrs. Lawrence..Zionsville
Harvey, Mrs. Ralph.....Zionsville

CARROLL COUNTY

Van Kirk, Mrs. John....Burlington
Brown, Mrs. Thomas C.....Delphi
Crampton, Mrs. C. C.....Delphi
Gros, Mrs. Hubert.....Delphi
Maggart, Mrs. Ralph.....Delphi
Wagoner, Mrs. George.....Delphi
Adams, Mrs. Max R.....Flora
McLaughlin, Mrs. James.....Flora

CASS COUNTY

Dutchess, Mrs. C. T.....Galveston
Lybrook, Mrs. D. E.....Galveston

Logansport

Adamski, Mrs. M. S.....614 17th
Bailey, Mrs. E. W.....2522 North
Ballard, Mrs. C. A.....R. R. 4
Bradfield, Mrs. John.....R. R. 4
Cooper, Mrs. T. L.....2104 North
Davis, Mrs. John.....2119 North
Fitzgerald, Mrs. Brice...1930 High
Hall, Mrs. B. R...1707 E. Broadway
Hedde, Mrs. E. L.....R. R. 5
Hickman, Mrs. W. R.....824 High
Hillis, Mrs. L. J..2508 E. Broadway
Holloway, Mrs. W. A.
200 Eel River
Holmes, Mrs. W. W.....R. R. 4
Jewell, Mrs. E. B.....3019 S. Penn.
Jones, Mrs. J. C.....R. R. No. 3
Keefe, Mrs. Thos..900 E. Broadway
Maxwell, Mrs. J. B.....1119 High
Morrical, Mrs. Russell
920 Michigan
Morrow, Mrs. G. W.
Longcliff St. Hosp.
Schenck, Mrs. Foss
Longcliff St. Hosp.
Shultz, Mrs. Harry....412½ Fourth
Viney, Mrs. C. L.....R. R. 4
Wilson, Mrs. Paul.....207 18th
Winter, Mrs. D. K..2541 Broadway

Newcomb, Mrs. W. K..Royal Center
Flanagan, Mrs. E. P.....Walton

CLARK COUNTY

Bottorff Mrs. D. C. . . 493 Harrison Charlestown
Goodman, Mrs. Eli 802 Market St., Charlestown
Patterson, Mrs. C. L. 1415 Tunnel Mill Rd., Charlestown
Willner, Mrs. Alan 117 N. Randolph, Clarksville
Greene, Mrs. W. R. . . . . Henryville

Jeffersonville

Adair, Mrs. S. L. . . . . Utica Pike
Bizer, Mrs. Mier . . 218 Kewanna Dr.
Buckley, Mrs. E. P. . . . . 14 Blanchel
Burman, Mrs. R. G. . . . . Utica Pike
Carlberg, Mrs. D. L. . . . . 2 Blanchel
Carney, Mrs. J. T. . . . . 203 Sparks
Clark, Mrs. Wm. B., Jr. 230 Chippewa Dr.
Dare, Mrs. L. A. . . . . 215 Sparks
Forsee, Mrs. N. E. . . . . 516 E. Court
Graham, Mrs. O. P. . . . 713 E. Maple
Huoni, Mrs. J. S. . . . 6 Blanchel Ter.
Isler, Mrs. Nathaniel 915 Morningside Dr.
Weems, Mrs. M. P. . . Hopkins Lane
Wilber, Mrs. H. R. Bonnenberger Subdiv.

Sellersburg

Regan, Mrs. George
Sturgis, Mrs. Donald G.
Vandevert, Mrs. Arthur

Mercer, Mrs. H. A. . Louisville, Ky.

CLAY COUNTY

Brazil

Maurer, Mrs. J. F. . . . . 6 E. Park
Maurer, Mrs. R. M. . . 1115 N. Meridian
Palm, Mrs. J. M. . . . . 27 E. Church
Sourwine, Mrs. C. C. . 141 N. Walnut
Weaver, Mrs. T. M. . . . . R. R. 2
Webster, Mrs. R. K. . . . . 25 Beech
Wood, Mrs. Opal L. . . 428 E. Blaine

Clay City

Bond, Mrs. W. C. . . . . 8th & White
Glosson, Mrs. J. R. . . . . 316 N. Main

Ward, Mrs. H. H. . . . . Coalmont

DAVIESS-MARTIN COUNTIES

Rohrer, Mrs. James . . . . . Elnora
Chattin, Mrs. Robt. . . . . Loogootee
Lett, Mrs. E. B. . . . . Loogootee
McCracken, Mrs. J. . . . Montgomery
Coleman, Mrs. H. G. . . . . Odon
Sears, Mrs. Don . . . . . Odon
Maschmeyer, Mrs. Robt. . . . . Shoals

Washington

Blazey, Mrs. A. . . . . E. Walnut
Burress, Mrs. B. . . . . Pine Court
Chattin, Mrs. Vance . . . . Greenacres
Denny, Mrs. Rankin . . S. Side Ave.
Farris, Mrs. J. J. . . . . 411 William
Fox, Mrs. Philip . . . . . Greenacres
Lindsay, Mrs. H. B. . . . . 14 SE Fifth
Lloyd, Mrs. C. A. . . . N. E. Second
McKittrick, Mrs. Jack . . Greenacres
McKittrick, Mrs. W. A. . Greenacres
McNaughton, Mrs. L. M. 812 E. Main
Norton, Mrs. Horace . . . 511 Hefron
Rang, Mrs. Arthur . . . . 211 E. Ninth
Rang, Mrs. Robert . . . . 214 E. Ninth
Schafer, Mrs. Wm. C. 1312 Bedford Rd.
Schroeder, Mrs. Roland . E. Walnut
Shield, Mrs. Harry 1210 Bedford Rd.
Smoot, Mrs. Brayton . . . . Troy Rd.

DEARBORN-OHIO COUNTIES

Aurora

Baker, Mrs. L. M. . . . . 204 Fifth
Olcott, Mrs. C. W. . . . 305 Sunnyside
Stewart, Mrs. O. H. 2nd & Bridgeway
Treon, Mrs. J. F. . . . . 505 Fifth

McNeeley, Mrs. M. J. . . . . Dillsboro
Elliott, Mrs. J. C. . . . . Guilford

Lawrenceburg

Fagaly, Mrs. W. J. . . . . 55 Oakey
Pfeifer, Mrs. J. M. . . . . 550 Ludlow
Streck, Mrs. F. A. . . . . Ridge Ave.
Vail, Mrs. G. A. . . . . 34 Oakey

Fessler, Mrs. Gordon . . . Rising Sun
Manley, Mrs. C. N. . . . . Rising Sun

DECATUR COUNTY

Tremain, Mrs. M. A. . . . . Adams

Greensburg

Acher, Mrs. Robert P. 446 E. Wash.
Blemker, Mrs. R. M. . 332 E. North
Callaghan, Mrs. W. C. Lincoln Park, R. R. 1
Dickson, Mrs. D. D. 825 N. Broadway
Miller, Mrs. J. C. . 178 N. Mich. Ave.
McKee, Mrs. H. S. 190 N. Mich. Ave.
Morrison Mrs. Trevor J. 511 N. Franklin
Overpeck, Mrs. Chas. 728 N. Broadway
Sallee, Mrs. Wm. T. 137 W. Hendricks

Porter, Mrs. Earl A. . . . . Westport

DELAWARE-BLACKFORD COUNTIES

Brown, Mrs. Stewart . . . . . Albany
Hurley, Mrs. John . . . . . Daleville
Tucker, Mrs. O. A. . . . . Daleville
Downard, Mrs. Leland . . . . . Gaston
Langsdon, Mrs. Fred . . . . . Gaston
Montgomery, Mrs. Lall . . . Gaston
Douglas, Mrs. Paul . . . . . Montpelier

Muncie

A

Adams, Mrs. Wm. B. W. Jackson St. Pike
Alvey, Mrs. C. R. . . . . 3001 Torquay
Anthony, Mrs. H. M. 822 W. Charles

B

Ball, Mrs. C. A. . . . . 1015 Linden
Bibler, Mrs. H. E. . . . . Parkway Dr.
Botkin, Mrs. C. G. . . 2904 Riverside
Botkin, Mrs. Tom 1007 W. North Ave.
Bowles, Mrs. Herman . . 324 N. Vine
Bowles, Mrs. J. H. . . . . 408 Wayne
Brown, Mrs. K. T. . . . 905 E. Adams
Brown, Mrs. Leland . . . . 2012 W. 9th
Brown, Miss Nellie G. . . Range Rd.
Brown, Mrs. Tom . . . . 2117 W. 10th
Butterfield, Mrs. Robert 1002 W. Gilbert

C

Clauser, Mrs. E. H. . . . . 1 Briar Rd.
Clevenger, Mrs. J. H. 3124 University
Cole, Mrs. R. E. . . . . 431 W. Howard
Covalt, Mrs. W. E. . . . N. Tillotson
Cure, Mrs. E. T. . . . . 913 University

D

Davis, Mrs. E. C. . . . . 45 Warwick
Deutsch, Mrs. Wm. . . . . 2100 Petty
Dunn, Mrs. F. W. . . . 1416 Wheeling

E

Egbert, Mrs. Clarence . 2010 S. Vine
Eissman, Mrs. Eugene 2724 W. Gilbert

F

Fitch, Mrs. John . . 1708 W. Jackson
Funk, Mrs. John 3700 Peachtree Lane

G

Garling, Mrs. L. C. . . . . 37 Briar Rd.
Gilbert, Mrs. N. G. . . Granville Pike
Greiber, Mrs. Marvin . . . 3001 Devon
Gustafson, Mrs. Milton . . . 920 Riley

H

Hall, Mrs. Orval . . . 3121 W. Gilbert
Hayes, Mrs. T. R. . . . . 920 W. North
Henderson, Mrs. Ramon 300 Shady Lane
High, Mrs. Ralph . . 2825 University
Hill, Mrs. Frank . . . . 321 N. Calvert
Hill, Mrs. Howard . . 402 W. Jackson
Hill, Mrs. Robert . State Rd. 3 South
Hostetter, Mrs. I. S. . 3010 Riverside
Hurley, Mrs. Anson 1007 University

I

Imhof, Mrs. Jos. 307 Granville Ave.

K

Kammer, Mrs. Walter . 919 W. Main
Kemper, Mrs. Arthur . 600 E. Wash.
Kirshman, Mrs. Forrest 41 Briar Rd.
Kuder, Mrs. Howard 1208 N. Walnut

M

Mason, Mrs. Lester . . . 3013 Oaklyn
Miller, Mrs. Charles . . St. Rd. 67 N.
Molloy, Mrs. W. J. . . 619 E. Charles
Morris, Mrs. J. W. 222 Stradling Rd.
Moss, Mrs. M. J. . . . . 2526 W. Main
McClellan, Mrs. John 613 W. Charles
McClintock, Mrs. James 316 W. Adams
McCoy, Mrs. George . 222 E. Adams

DELAWARE-BLACKFORD COUNTIES

(Muncie—Continued)

O-P-Q

Owens, Mrs. O. W. . . . 2600 Godman
Owens, Mrs. Richd. . . . 2613 Godman
Owens, Mrs. Thos. . . 608 E. Charles
Poland, Mrs. U. G. . . . . 303 E. Wash.
Quick, Mrs. Wm. . . 2009 University

R

Rea, Mrs. C. G. . . . . 412 University
Rettig, Mrs. Arthur . 611 W. Howard
Rivers, Mrs. Glynn . 1333 N. Walnut

S

Schulhoff, Mrs. M. G.
1408 Wheeling
Silvers, Mrs. J. C. 319 S. Franklin
Silvers, Mrs. J. M. . . 220 W. Adams
Stocking, Mrs. Bruce . 3014 Amhurst

T-V

Tindal, Mrs. Edw. . . 423 W. Jackson
Tomlin, Mrs. H. M. . . . 921 W. Main
Trent, Mrs. I. N. . . . . 415 E .Adams
Venis, Mrs. Kemper . . . . . 502 Wade

W

Wadsworth, Mrs. W. W.
306 E. Jackson
Williams, Mrs. J. H. . 905 W. North
Wright, Mrs. C. H. . . . . 715 Rex

Y

Young, Mrs. Gerald . . . . 114 Berwyn

Hinchman, Mrs. Jean . . . . . Parker
Moore, Mrs. Will . . . . . Yorktown

DUBOIS COUNTY

Backer, Mrs. H. G. . . . . Ferdinand

Huntingburg

Bretz, Mrs. John . . . 222 Van Buren
Bretz, Mrs. W. D. . . . . 214 Fourth
Steinkamp, Mrs. E. F. . . 302 Walnut
Stork, Mrs. H. K. . . . . 523 First
Williams, Mrs. F. P. . . . . 511 Geiger

Jasper

Casper, Mrs. John . . . . . R. F. D. 5
Casper, Mrs. Jos. . . Terrace Heights
Greenberg, Mrs. R. E.
738 W. 13th
Heck, Mrs. M. C. . . . . 388 W. 15th
Held, Mrs. G. A. . . Terrace Heights
Klamer, Mrs. C. H. . . . 424 W. Sixth
Wagoner, Mrs. J. M. . Terrace Hgts.

ELKHART COUNTY

Bristol

Neidballa, Mrs. E. G. . . . . R. F. D. 1
Patrick, Mrs. G. B. . . . . R. F. D. 1
Schlosser, Mrs. H. C. Seven Gables

Stubbins, Mrs. Wm.
R. F. D. 1, Dunlap

Elkhart

Bender, Mrs. R. L. . . 309 East Blvd.
Billings, Mrs. Elmer . . 327 Emerald
Bloom, Mrs. G. R. . . . . 130 Glendale
Bolin, Mrs. R. S. . 1853 E. Beardsley
Bowdoin, Mrs. G. E.
1029 W. Lexington
Compton, Mrs. W. A.
2225 Greenleaf
Conklin, Mrs. R. L.
1906 E. Jackson
Cormican, Mrs. Herbert L.
1621 E. Jackson
Crandall, Mrs. L. A.
Crandall's Pond, R. F. D. 3
Elliott, Mrs. L. A. . . . . 2001 Stevens
Fleming, Mrs. C. F. . 229 W. Jackson
Fleming, Mrs. J. M.
2220 E. Jackson
Horswell, Mrs. R. G.
1629 E. Jackson
Hull, Mrs. A. W. . . . . 905 Strong
Hunn, Mrs. M. E. 202 W. Beardsley
Kintner, Mrs. B. E. . 3520 E. Jackson
Kistner, Mrs. A. W.
102 W. Beardsley
Koehler, Mrs. E. G.
807 N. Shore Dr., Simonton Lake
Logan, Mrs. Richard . 321 Hubbard
Lundt, Mrs. M. O. . . . 519 S. Second
Markel, Mrs. I. J. . . 215 W. Franklin
Mendez, Mrs. Carlos . . 325 Superior
Miller, Mrs. H. A., Jr.
309 E. Crawford
Miller, Mrs. S. T. . . . . 1230 Prairie
Mininger, Mrs. E. P.
413 W. Franklin
Mishkin, Mrs. Irving
217 N. Riverside Dr.
Paff, Mrs. W. A. 2601 E. Jackson
Paine, Mrs. G. D. . . . . 419 Modrell
Possolt, Mrs. Thos. 2806 E. Jackson
Rupe, Mrs. Lloyd O.
116 W. Dinehart
Sears, Mrs. M. M.
R. F. D. 3 West Indiana
Spray, Mrs. Page . . . . 658 Kilbourne
Stauffer, Mrs. W. A. . . . . 701 Strong
Stout, Mrs. R. B. . . . 1501 Greenleaf
Swihart, Mrs. H. R. . 417 N. Second
Swihart, Mrs. L. F . 2120 Broadmoor
Todd, Mrs. D. D. . . . 2001 E. Jackson
Wilson, Mrs. O. E.
2505 Greenleaf Blvd.
Work, Mrs. Jas. A., Jr.
4 St. Joseph Manor
Yoder, Mrs. C. R. . . . 130 N. Corona

Goshen

Amstutz, Mrs. H. C. . . 2001 S. Main
Bender, Mrs. C. K. . . . . 624 S. Fifth
Freeman, Mrs. F. M. . . 309 E. Wash.
Hostetler, Mrs. C. M. . . . 1602 S. 8th
Kelly, Mrs. W. R. . . . 310 E. Monroe
Kinzie, Mrs. D. K. . . . . 406 Sunset
Martin, Mrs. F. S. . . . . R. F. D. 5
Nelson, Mrs. D. C. . . 1210 S. Eighth
Simmons, Mrs. L. H. . . 606 S. Third
Turner, Mrs. John . . . . R. R. No. 2
Vander Bogart, Mrs. H. E.
1411 S. Eighth
Yoder, Mrs. A. C. . . . . 816 S. Sixth

Norris, Mrs. E. B. . . . . Middlebury

Nappanee

Fleetwood, Mrs. R. A.
151 E. Van Buren
Kendall, Mrs. F. M. 801 E. Market
Price, Mrs. D. W. . . 458 N. Madison
Price, Mrs. M. D. . . 451 N. Hartman
Slabaugh, Mrs. Lotus . . 402 N. Main
Slabaugh, Mrs. J. S.

Fosbrink, Mrs. E. L. . . . . Syracuse
Hannah, Mrs. Jack W. . . . Wakarusa
Elliott, Mrs. T. A. . 4577 Utopia Dr.,
New Orleans 20, La.

FAYETTE-FRANKLIN COUNTIES

Foreman, Mrs. Walter . . Brookville
Seal, Mrs. Perry . . . . . Brookville
Smith, Mrs. H. N. . . . . Brookville

Connersville

Ashworth, Mrs. L. N.
2027 Indiana Ave.
Booher, Mrs. Martha
1609 Virginia Ave.
Brockman, Mrs. R. E.
2750 Grand Ave.
Cavitt, Mrs. R. F. . . . . 825 W. 8th
Clark, Mrs. Helen N.
401 Western Ave.
Dale, Mrs. M. H. . 817 Lincoln Ave.
Fettig, Mrs. Lucille
1609 Virginia Ave.
Fruth, Mrs. V. J.
1603 Virginia Ave.
Gregg, Mrs. A. F. . 835 Lincoln Ave.
Kemp, Mrs. W. A. . . . . 403 W. 28th
Leffel, Mrs. Glenn
1810 Indiana Ave.
Lockhart, Mrs. J. M.
2918 Vermont Ave.
Metcalf, Mrs. Alma
1805 Virginia Ave.
Moore, Mrs. Hollis . 126½ W. 11th
Morrow, Mrs. Roy D.
1708 Virginia Ave.
Mountain, Mrs. F. B.
1720 Virginia Ave.
Smelser, Mrs. H. W.
2530 N. Grand Ave.
Watterson, Mrs. G. T.
1910 Virginia Ave.

FLOYD COUNTY

Engleman, Mrs. H. K. . Georgetown

Jeffersonville

Baxter, Mrs. S. M. . . . Centralia
McCullough, Mrs. J. Y. . . Centralia
Sloan, Mrs. H. P. . . . . Lincoln Hts.

New Albany

Baker, Mrs. A. M. . . 2523 Glenwood
Baxter, Mrs. Jas. W., Jr.
426 Woodrow
Baxter, Mrs. Jas. W., Sr.
1201 E. Spring
Bird, Mrs. J. E. . . . . 1308 E. Spring
Briscoe, Mrs. C. E. . 1413 E. Spring
Brown, Mrs. K. H. . . . . 1654 Hedden
Byrn, Mrs. H. W. . . . . 330 Beharrell
Cannon, Mrs. D. H. . . . . Crestview
Davis, Mrs. P. M. . . . . Paoli Pike
Day, Mrs. G. H. . . . . Haufeldt Lane
Edwards, Mrs. W.F. . . 615 Beharrell
Garner, Mrs. W. H. . . 922 E. Spring
Hauss, Mrs. A. P. . . . . Silver Hills
Hess, Mrs. Patrick . . . . . Lilly Lane
LaFollette, Mrs. R. E.
2510 Glenwood Pk.
Leuthart, Mrs. C. P. . 1410 E. Spring
Pace, Mrs. Jerome
Old Vincennes Rd.
Paris, Mrs. J. M. . . . 2003 Lindbergh

FLOYD COUNTY
(New Albany—Continued)

Pierson, Mrs. P. R. . . . . 1430 Silver
Robertson, Mrs. A. N. . 323 E. Ninth
Rogers, Mrs. S .T. . . 1017 E. Spring
Schoen, Mrs. P. H. . . . . 1825 State
Streepey, Mrs. J. I.
1919 DePauw Ave.
Tyler, Mrs. F. T. . . . . Daisy Lane
Voyles, Mrs. H. E. . . . 425 Beharrell
Weaver, Mrs. W. W. . 1104 E. Spring
Winstandley, Mrs. W. C.
815 Vincennes
Wolfe, Mrs. N. A. . . . . 1111 Spring

FULTON COUNTY

Miller, Mrs. Virgil . . . . . Akron
Stinson, Mrs. A. E. . . . . Athens
Kelsey, Mrs. Lawrence . . . Kewanna
Kraning, Mrs. K. K. . . . . Kewanna
Dielman, Mrs. F. C. . . . . Rochester
Herendeen, Mrs. E. V. . . . Rochester
Glackman, Mrs. John . . . . Rochester
King, Mrs. Milo O. . . . . Rochester
Richardson, Mrs. C. L. . . . Rochester
Rowe, Mrs. Howard . . . . . Rochester
Stinson, Mrs. Dean K. . . . Rochester

GIBSON COUNTY

Geick, Mrs. R. G. . . . . Ft. Branch
Hollis, Mrs. W. H. . . . . Ft. Branch
Klein, Mrs. H. P.
206 S. Main, Ft. Branch
Arthur, Mrs. H. M. . . . . Hazelton

Oakland City

Clark, Mrs. C. M. . 511 W. Columbia
Turner, Mrs. M. A.
322 W. Columbia
Wood, Mrs. R. W. . . . . 628 W. Oak

Geller, Mrs. S. N. . . . . Owensville
Montgomery, Mrs. J. R. . Owensville
Strickland, Mrs. K. S. . . . Owensville
Arthur, Mrs. M. L. . . . . Patoka

Princeton

Alexander, Mrs. H. H. . 427 W. State
Carpentier, Mrs. H. F. . 319 E. State
Folck, Mrs. John K. . . . 530 N. Hart
Graves, Mrs. O. M. . . . 116 E. Spruce
McCarty, Mrs. V. . . . 403 W. Spruce
McElroy, Mrs. R. S. . . . 704 W. State
Maxam, Mrs. F. H. . . . . 426 N. Main
Peck, Mrs. James F.
218 W. Broadway
Weitzel, Mrs. R. E. . 309 W. Spruce

GRANT COUNTY

Malott, Mrs. Fred . . . . . Converse
Garrison, Mrs. Leon . . . . . Gas City
Koontz, Mrs. William . . . . . Gas City

Marion

Abell, Mrs. Chas. F. . . Wabash Ave.
Currie, Mrs. Robert
Daniels, Mrs. George . . . 822 W. 4th
Diamond, Mrs. L. L.
617 Spencer Ave.
Eshleman, Mrs. L. H. . 2923 S. Wash.
Dick, Mrs. Fred
Ganz, Mrs. Max . . . . . Euclid Ave.
Fisher, Mrs. P. J. . . . . 1714 E. 34th
Ginsberg, Mrs. S. T. . . 32 Vet. Hosp.
Hummel, Mrs. R. M. . . . . Shady Hill
Lavengood, Mrs. R.
Long, Mrs. Max
McIlwain, Mrs. Robert (Dr.)
2170 S. Boots
Powell, Mrs. J. Paxton . . . River Dr.
Renbarger, Mrs. Lester
Wabash Pike
Rohrer, Mrs. John G. . . 711 Wabash
Simmons, Mrs. Fred H. . 520 Whites
Skomp, Mrs. C. E.
Warren, Mrs. Carrol . . . . 803 W. 6th

King, Mrs. P. C. . . . . Swayzee
Taylor, Mrs. E. C. . . . . Upland

HAMILTON COUNTY

Connoy, Mrs. Leo . . . . . Carmel
Heek, Mrs. Sam . . . . . Carmel
Ambrose, Mrs. Jesse . . . Noblesville
Campbell, Mrs. Sam . . . . Noblesville
Hash, Mrs. John S. . . . . Noblesville
Kraft, Mrs. Haldon . . . . Noblesville
Shonk, Mrs. Harold . . . . Noblesville
Shanks, Mrs. Ray . . . . . Noblesville
Connoy, Mrs. A. F. . . . . Westfield
Donahue, Mrs. C. M. . . . . Westfield

HANCOCK COUNTY

Scott, Mrs. Robert . . . Charlottsville
Ferrell, Mrs. J. E. . . . . Fortville
Navin, Mrs. H. K. . . . . Fortville

Greenfield

Allen, Mrs. Joseph . . . . 17 E. South
Allen, Mrs. Paul . . . . 212 N. Swope
Endicott, Mrs. W. H. . . . N. East St.
Gibbs, Mrs. Chas. . . . . 203 E. North
Gill, Mrs. D. D. . . . . 328 Park Ave.
Grier, Mrs. R. N. . . . 332 E. North
Henn, Mrs. R. A. . . . . 707 N. State
McIntosh, Mrs. Sam . . . . . Grant St.
Vingis, Mrs. Bronie . . 705 N. State
Woods, Mrs. James . . . . N. East St.
Larrabee, Mrs. W. H.
New Palestine

Kuhn, Mrs. Robert . . . . . Wilkinson

HENDRICKS COUNTY

Foltz, Mrs. L. E. . . . . Brownsburg
Scudder, Mrs. A. N. . . . Brownsburg
Ellett, Mrs. John, Jr. . . . Coatesville
Gibbs, Mrs. J. W. . . . . Danville
Koch, Mrs. E. . . . . Danville
Price, Mrs. Ernest H. . . . . Danville
Terry, Mrs. Lloyd . . . . . Danville
Ellis, Mrs. L. H. . . . . Lizton
Grimes, Mrs. J. H. . . . Martinsville
Scamahorn, Mrs. M. . . . . Pittsboro
Scamahorn, Mrs. O. T. . . . Pittsboro
Cohen, Mrs. Irving . . . . . Plainfield
Stafford, Mrs. J. C. . . . . Plainfield
Stafford, Mrs. W. C. . . . . Plainfield

HENRY COUNTY

Clark, Mrs. M. E. . . Cambridge City
Zimmerman, Mrs. W. H. . . . . Dublin
Stauffer, Mrs. George . . . Mooreland
Marshall, Mrs. L. C. . . . Mt. Summit
Shallenberger, Mrs. H. . . . . Modoc

New Castle

Bitler, Mrs. C. C. . . . . 606 S. 11th
Blaize, Mrs. J. A. . . . . P. O. B. 34
Bledsoe, Mrs. J. G. . . . . 319 S. 14th
Burnett, Mrs. Arthur 1201 S. Main
Canaday, Mrs. C. E. . . . 1411 Church
Craig, Mrs. Alex . . . . . New Road
Fisher, Mrs. John . . . . . 438 S. 11th
Foster, Mrs. Ray . . . . . 420 N. Main
Harrison, Mrs. B. L.
233 Bundy Ave.
Heilman, Mrs. W. C.
1111 Audubon Rd.
Hill, Mrs. Kenneth
1224 Audubon Rd.
Iterman, Mrs. George 925 Maurer
Kennedy, Mrs. W. U. . 701 S. 14th
Life, Mrs. Homer L. . . . . 1015 Broad
McDonald, Mrs. Frank 524 S. 11th
McElroy, Mrs. James
1230 Audubon Rd.
Smith, Mrs. R. A.
1229 Lincoln Ave.
Stout, Mrs. Walter
1103 Audubon Ave.
Thorne, Mrs. Charles 1119 S. Main
Wiggins, Mrs. D. S. . . 219 S. 12th
Wiggins, Mrs. George . 403 N. Main

HOWARD COUNTY

Denton, Mrs. Larkin . . . . Greentown
Shoup, Mrs. H. B. . . . . Greentown

Kokomo

Adams, Mrs. C. J.
1216 W. Superior
Alward, Mrs. H. H. 401 W. Walnut
Boughman, Mrs. J. D.
1515 W. Jefferson
Bowers, Mrs. Copeland
1530 W. Taylor
Bowers, Mrs. Garvey
421 Morningside
Bowers, Mrs. John
1535 W. Jefferson
Bruegge, Mrs. T. J. . . 1414 Kingston
Clarke, Mrs. Elton
1400 W. Superior
Conley, Mrs. Thomas
1016 W. Superior
Craig, Mrs. Rueben . 113 Leafy Lane
Crawford, Mrs. T. R.
908 W. Superior
Cuthbert, Mrs. F. S. 1027 W. Walnut
Earl, Mrs. Max . . . 409 W. Taylor
Ferry, Mrs. Paul. 1207 W. Sycamore
Good, Mrs. Richard . . . . 417 Conradt
Halfast, Mrs. Richard
310 W. Markland
Hutto, Miss Arvilla
1012 W. Walnut
Hutto, Mrs. Omer . 1012 W. Walnut
Hutto, Mrs. W. H. . . . . 211 Conradt
Jewell, Mrs. Geo. . . 1525 W. Walnut
Kratzer, Mrs. E. F. . 320 W. Walnut
Lung, Mrs. Bruce . . . . . 115 Conradt
McIndoo, Mrs. R. E. 820 W. Walnut
Meiner, Mrs. J. A. . . . 924 W. Wash.
Morford, Mrs. Guy
1017 W. Superior
Morrison, Mrs. W. R. . . 413 Conradt
Murray, Mrs. Ernest . 1329 W. Jeff.
Paris, Mrs. Durward S. LaFountain
Phares, Mrs. Robert
905 W. Mulberry
Rhorer, Mrs. H. M.
511 W. Sycamore
Schuler, Miss Lucy . . . . 502 N. Main
Schuler, Mrs. R. P. . . . . 502 N. Main
Schwartz, Mrs. Frederick
1502 Kingston Rd.
Shenk, Mrs. E. M. . . 306 N. Webster
Sorensen, Mrs. Raymond
1732 W. Walnut
Spangler, Mrs. Jesse
2100 S. Webster

Evans, Mrs. Robert . . . . Russiaville
Tranter, Mrs. Frank . . . Sharpsville

HUNTINGTON COUNTY

Huntington

Brubaker, Mrs. H. S....919 Poplar
Casey, Mrs. S. M....408 E. Market
Clunie, Mrs. Wm. A.
502 N. Jefferson
Cope, Mrs. Stanton...1022 N. Jeff.
Erehart, Mrs. M. G.
232 W. Market
Eviston, Mrs. J. B....1392 Poplar
Galbreath, Mrs. R. S...16 W. Wash.
Gray, Mrs. Paul M...340 E. Market
Grayston, Mrs. Fred W..708 N. Jeff.
Grayston, Mrs. W. S..303 E. Market
James, Mrs. Thos., Jr.
1044 Poplar
Johnston, Mrs. R. G..339 E. Market
Marks, Mrs. H. H.....1433 Cherry
Mitman, Mrs. F. B.....1470 Poplar
Nie, Mrs. G. M.....1518 Cherry
Omstead, Mrs. T. W.
244 E. Washington
Ware, Mrs. J. R.....622 Henry

Woods, Mrs. H. C.....Markle
Bennett, Mrs. J. B.....Warren
Black, Mrs. Claude S.....Warren
Bonifield, Mrs. H. F.....Warren
Smith, Mrs. L. W.....Warren

JASPER-NEWTON COUNTIES

Pippenger, Mrs. Wayne .....Brook
Openshaw, Mrs. J. F.....Goodland
Smith, Mrs. Hunter L...Goodland
Glick, Mrs. O. E.....Kentland
Yegerlehner, Mrs. R. S...Kentland
Donavan, Mrs. J. W.....Morocco
Schubert, Mrs. J. C.....Morocco
Schantz, Mrs. Richard..Remington
Sink, Mrs. Frank .....Remington
Beaver, Mrs. E. R.....Rensselaer
English, Mrs. Harry ...Rensselaer
Kresler, Mrs. L. E.....Rensselaer
O'Neill, Mrs. M. J.....Rensselaer
Schumaker, Mrs. Eugene
Rensselaer
Tate, Mrs. Wallace.....Thayer

JAY COUNTY

Portland

Badders, Mrs. A. C...709 W. North
Dulin, Mrs. Basil B....321 E. Race
Engle, Mrs. John Max
503 W. Walnut
Fitzpatrick, Mrs. J. S.
204 N. Pleasant
Hammond, Mrs. Stanley Mead
Hennessee, Mrs. Philip C.
603 W. Arch
Keeling, Mrs. Forrest E.
609 W. Race
Moran, Mrs. Mark M.
403 E. Walnut
Morrison, Mrs. George G.
North & Park St.
Spahr, Mrs. Donald E..615 W. Race
Schwartz, Mrs. W. D...234 E. High

Hanna, Mrs. Duke.....Redkey

JEFFERSON COUNTY

Madison

Childs, Mrs. W. E.....Elm & Third
Jolly, Mrs. L. E.....J.P.G. Area
Kemp, Mrs. M. W...Mad. St. Hosp.
May, Mrs. G. A.....R.F.D. 5
Petway, Mrs. A. P.....411 W. First
Rains, Mrs. Rinda..Madison Hosp.
Whitsitt, Mrs. S. A....718 W. Main
Zink, Mrs. R. O.....426 Vine

JENNINGS-JACKSON COUNTIES

Gillespie, Mrs. G. R...Brownstown
Shields, Mrs. Jack....Brownstown
Adair, Mrs. W. K....Crothersville
Bard, Mrs. F. B.....Crothersville
Cummings, Mrs. D. J.....Ewing
Brown, Mrs. Merle S.
North Vernon
Green, Mrs. John...North Vernon
Matthews, Mrs. D. W.
North Vernon
Thayer, Mrs. Benet..North Vernon

Seymour

Black, Mrs. J. M.....315 N. Pine
Day, Mrs. Durbin .....515 W. 6th
Elsner, Mrs. L. W.....503 W. 6th
Gillespie, Mrs. Chas. E.
602 N. Walnut
Graessle, Mrs. H. P.
419 N. Walnut
Graessle, Mrs. Lucy
603 S. Chestnut
Kamman, Miss Martha..332 W. Oak
Martin, Mrs. Guy..1408 Ewing Rd.
Miller, Mrs. Harold....733 W. 7th
Osterman, Mrs. L. H.
901 Garden Ave.
Ripley, Mrs. J. W.....321 Bruce
Shortridge, Mrs. W. H.
313 Carter Blvd.
Wiethoff, Mrs. C. A.
327 Calvin Blvd.

JOHNSON COUNTY

Edinburg

Baker, Mrs. J. F.
215 W. Main Cross
Lutes, Mrs. D. L.
209 E. Main Cross
Michaels, Mrs. J. F.
207 E. Main Cross

Franklin

Deppe, Mrs. Chas. F.....1215 Park
Eaton, Mrs. L. D..651 W. Jefferson
Ferrara, Mrs. Jos....1000 E. King
Jones, Mrs. Chas. A..589 N. Graham
Manuel, Mrs. D. C....89 N. Walnut
Murphy, Mrs. H. E....150 N. Main
Murphy, Mrs. Geo...422 N. Walnut
Payne, Mrs. Carl F....151 N. Main
Portteus Mrs. W. L..Forsythe St.
Province, Mrs. O. A...99 N. Water
Province, Mrs. W. D..186 Maple La.
Records, Mrs. Arthur W.
216 E. Jefferson
Wilson, Mrs. R. C.....351 E. King

Greenwood

Brown, Mrs. G. E..Beech Park Dr.
Craig, Mrs. J. A.....E. Pearl St.
Machledt, Mrs. John
243 S. Madison
Sheek, Mrs. K. I.....165 N. Brewer
Tiley, Mrs. Geo. A...41 N. Madison
Woodcock, Mrs. Charles E.
240 S. Madison

KNOX COUNTY

Scudder, Mrs. J. A...Edwardsport
Raper, Mrs. G. T.....Freelandville
Springstun, Mrs. George..Oaktown

Vincennes

Anderson, Mrs. R. M.
Monroe City Rd.
Arbogast, Mrs. P. B.
1420 Old Orchard Rd.
Beckes, Mrs. E. W.....220 N. 5th
Chattin, Mrs. H. O.....729 Main
Coffel, Mrs. M. H.....929 Perry
Curtner, Mrs. M. L.....715 Buntin
Edwards, Mrs. E. T., Jr.
1232 N. 11th
Ewing, Mrs. N. D.
Monroe City Rd.
Fox, Mrs. M. S.....704 N. 7th
Frigge, Mrs. E. H.....609 Main
Green, Mrs. Carl
Humphreys, Mrs. Joe E.
McCormick, Mrs. H. D. 518 N. 4th
McDowell, Mrs. M. M.
1322 Audubon Rd.
McMahan, Mrs. V. C.
Old Wheatland Rd.
Nance, Mrs. W. K.....720 Perry
Richards, Mrs. D. H..904 Busseron
Reilly, Mrs. J. F.....401 Buntin
Schulze, Mrs. Wm.
Shaffer, Mrs. Kenneth
Small, Mrs. E. F.....526 Scott
Smith, Mrs. R. O.
Old Bruceville Rd.
Spencer, Mrs. F.....311 N. 9th
Stewart, Mrs. C. E.
Welch, Mrs. N. M.
Monroe City Rd.

Pierce, Mrs. Gene S.....Wheatland
Cullison, Mrs. Chas....Sumner, Ill.

KOSCIUSKO COUNTY

Leasure, Mrs. Kenneth..Etna Green
McIlroy, Mrs. R. J.....Claypool
Urschel, Mrs. Dan .....Mentone
Herring, Mrs. Geo. N.....Pierceton
Schuldt, Mrs. T. S.....Pierceton

Warsaw

Haymond, Mrs. G. M..532 E. Center
Leininger, Mrs. H. A. P.
1226 E. Market
Murphy, Mrs. S. C....216 S. Main
Richer, Mrs. O. H.....914 E. Main
Schlemmer, Mrs. G. H..528 N. Lake

LAKE COUNTY

Carmody, Mrs. R. F...Chesterton
Horst, Mrs. W. N.....Crown Point
Klaus, Mrs. J. M..... Crown Point
Troutwine, Mrs. W. R....Crown Pt.
Carleton, Mrs. E. H.....Dyer

East Chicago

Arnold, Mrs. M. F....4239 Magoun
Benchik, Mrs. Frank..4712 Magoun
Bonaventura, Mrs. Angelo P.
1604 142nd
Boys, Mrs. F. F.....4143 Northcote
Cotter, Mrs. E. R...4220 Homerlee
Cotter, Mrs. Thomas.....4221 Ivy
Ernst, Mrs. H. C.....4219 Baring
Fleischer, Mrs. J. C.....4135 Ivy
Grosso, Mrs. William G.
3205 Grand Blvd.

LAKE COUNTY

(East Chicago—Continued)

Gustaitis, Mrs. J. W. 4318 Parrish
Johns, Mrs. David R. 1211 Beacon
Niblick, Mrs. Jas. 4122 Parrish
O'Conner, Mrs. J. J. 3717 Ivy
Petronella, Mrs. S. J. 4308 Baring
Shapiro, Mrs. Jos. 3919 Fern

Mather, Mrs. J. W.
2367 Vigo, East Gary

Gary

Almquist, Mrs. C. O. 550 Lincoln
Behn, Mrs. Walter 652 McKinley
Bendler, Mrs. Carl
225 Morningside
Bills, Mrs. R. N. 534 Lincoln
Brady, Mrs. Saml. 451 Garfield
Brandman, Mrs. Harry 629 Grant
Brown, Mrs. David 6940 Forest
Brown, Mrs. L. R. 3746 Tyler
Carbone, Mrs. Jos. 526 Johnson
Chevigny, Mrs. J. J. 654 Johnson
Cooper, Mrs. Leo 670 Hayes
Dierolf, Mrs. Edw.
630 N. Montgomery
Elliott, Mrs. Ralph 1726 W. 6th
English, Mrs. Hubert 575 Taft Pl.
Goldberg, Mrs. H. 3645 Tyler
Goldstone, Mrs. Adolph 1430 W. 7th
Goldstone, Mrs. Jos. 600 Cleveland
Goldstone, Mrs. S. R. 566 Taft
Harris, Mrs. Donald 4813 Madison
Jannasch, Mrs. C. M. 332 Taft
Kahan, Mrs. Harry 403 Johnson
Kendrick, Mrs. Frank 552 Johnson
Kopcha, Mrs. Joseph 715 Hayes
Korn, Mrs. Jerome 3653 Polk
Korbin, Mrs. Meyer 2300 W. 6th
Lebioda, Mrs. Henry 3739 Adams
Lorenty, Mrs. T. B. 3654 Madison
May, Mrs. M. R. 667 Van Buren
Minczewski, Mrs. R. C. 351 Chase
Molengraft, Mrs. C. J. 534 Monroe
Morris, Mrs. Hyman 558 Taney Pl.
Moswin, Mrs. Jack 477 Arthur
Nesbit, Mrs. O. B.
444 Jackson Ave.
Ornelas, Mrs. J. P. 4124 Monroe
Palmer, Mrs. Russell 2006 W. 4th
Parratt, Mrs. L. W. 3526 Madison
Reynolds, Mrs. Jas. 7300 Maple
Robinson, Mrs. Walter
4024 E. 10th
Rubin, Mrs. Milton 574 Monroe
Rubin, Mrs. Simon 2131 W. 5th
Sala, Mrs. J. J. 2373 W. 5th
Sala, Mrs. Walter 2035 W. 8th
Senese, Mrs. T. J. 581 Johnson
Shellhouse, Mrs. M. 3671 Adams
Slama, Mrs. Geo. 3624 Buchanan
Spellman, Mrs. F. W. 640 Illinois
Stimson, Mrs. H. R. 4338 Jefferson
Verplank, Mrs. G. L. 57th St.
Vye, Mrs. Preston J. 3620 Madison
Wharton, Mrs. R. C. 703 Johnson
Wicks, Mrs. C. O. 560 Van Buren
Weiskopf, Mrs. H. 1720 W. 8th
Yocum, Mrs. Wm. 709 Johnson
Young, Mrs. G. M. 4580 Wash.

Lundeberg, Mrs. R. Griffith
Malmstone, Mrs. F. A. Griffith
Siekierski, Mrs. Jas. Griffith

Hammond

Allegretti, Mrs. Michael
37 Elizabeth
Arrowsmith, Mrs. Jas. 8138 Forest
Beconovich, Mrs. Robt. 839 169th
Beilke, Mrs. C. A. 6806 Huron
Chidlaw, Mrs. B. W.
29 Wildwood Rd.
Cook, Mrs. G. M. 6607 Forrest
Eggers, Mrs. Ernst 2237 169th
Eggers, Mrs. Henry 6542 Hohman
Elledge, Mrs. Ray 6415 Forrest
Ewing, Mrs. J. K. 55 Kenwood
Fischer, Mrs. B. 7403 Van Buren
Gevirtz, Mrs. M. B. 6528 Forrest
Hack, Mrs. E. C. 7174 Olcott
Hickman, Mrs. A. L. 614 165th
Hopkins, Mrs. J. R. 265 Conkey
Husted, Mrs. Robert 224 Fernwood
Jones, Mrs. E. S. 50 Kenwood
Kaplan, Mrs. Ben 2035 169th
Kenney, Mrs. F. D. 913 175th
Komoroske, Mrs. J. E. 35 Highland
Koransky, Mrs. David 7306 Tapper
Kretsch, Mrs. R. W. 7214 Hohman
Laze, Mrs. V. 734 Sibley
Marks, Mrs. O. L. 7111 Olcott
Marks, Mrs. S. P. 539 Cherry
Mathews, Mrs. C. B. 6416 Forrest
Modjeski, Mrs. R. 223 Locust
Nakadate, Mrs. K. J. 907 173d Pl.
Neal, Mrs. L. W. 2237 169th
Nelson, Mrs. R. B. 6741 Hohman
Panares, Mrs. S. V. 4 172nd Pl.
Peck, Mrs. Edward 411 Morain
Pilot, Mrs. Jean
7137 Knickerbocker Pkwy.
Premuda, Mrs. Frank
6545 Alexander
Remich, Mrs. A. C. 6412 Moraine
Rendel, Mrs. Donald 18 172nd
Rhind, Mrs. A. W. 7126 Forrest
Row, Mrs. P. Q. 6706 Hohman
Rudolph, Mrs. F. G. 216 Lawndale
Schlesinger, Mrs. J. 1251 Forrest
Shanklin, Mrs. E. M. 14 Ruth
Sroka, Mrs. S. 8608 Kennedy
Stern, Mrs. S. L. 226 Oakwood
Thegze, Mrs. Geo. 7435 Olcott
Tilka, Mrs. Edward 1037 River

Dupes, Mrs. L. E. 727 Main, Hobart

Lowell

Combs, Mrs. L. W.
N. Cedar Creek Twp.
Davis, Mrs. Neal
Mirro, Mrs. J. A.

Munster

Arbeiter, Mrs. Herbert 229 Beldon
Friedman, Mrs. I. E.
11 Beverly Pl.
Larrabee, Mrs. J. 8143 State Line
Rosevear, Mrs. Henry 230 Beldon

Whiting

Jones, Mrs. C. M. 1925 Westpark
Stecy, Mrs. Peter Whiting

Brown, Mrs. S. L.
13401 Brendon Ave., Chicago, Ill.
Potts, Mrs. William
3543 Ridgeway, Lansing, Ill.

LAPORTE COUNTY

Oak, Mrs. D. D., Sr. La Crosse

LaPorte

Carter, Mrs. Fred Jefferson Ave.
Cartwright, Mrs. J. D.
701 Kentucky Ave.
Farnsworth, Mrs. S. A. 117 Fox
Fischer, Mrs. C. N. 1001½ Maple
Jones, Mrs. R. B. 1515 Indiana
Kelsey, Mrs. Robt. M. 2107 Monroe
Kepler, Mrs. R. W. 1529 Michigan
Larson, Mrs. G. O. 1006 Monroe
Moosey, Mrs. Louis 2007 Mich.
Muhleman, Mrs. C. E. Greenacres
Przednowek, Mrs. A. C.
909 Madison
Richter, Mrs. John C. 1421 Indiana
VonAsch, Mrs. Geo.
707 Weller Ave.

Michigan City

Armstrong, Mrs. Thomas D.
E. Coolspring Ave.
Bankhoff, Mrs. M. L. 1412 Wash.
Fargher, Mrs. F. M.
Pottawattomie Park
Feerer, Mrs. Don 117 W. 7th
Flaherty, Mrs. W. T. Long Beach
Gardner, Mrs. M. D. 801 Wash.
Gardner, Mrs. R. A. Long Beach
Gilmore, Mrs. R. A. 815 Wash.
Jones, Mrs. King
Kemp, Mrs. John T. 631 Pine
Kerrigan, Mrs. J. V. E. Coolspring
Kling, Mrs. V.
2105 Oakenwald, Long Beach
Kohrman, Mrs. B. M.
3011 S. Franklin
Krieger, Mrs. George M.
701 Washington
Kubik, Mrs. F. J.
Pottawattamie Pk.
Meyer, Mrs. Milo G. Long Beach
Molenda, Mrs. R. V.
Piazza, Mrs. G. R. 2402 York
Plank, Mrs. C. R. Longbeach

Weinstock, Mrs. A. Rolling Prairie
Benz, Mrs. O. F. Wanatah

MADISON COUNTY

Anderson

Aagesen, Mrs. W. J. Forest Hills
Armington, Mrs. J. C. 206 E. 14th
Armington, Mrs. R. L. Kilbuck Rd.
Austin, Mrs. M. A. 238 W. 12th
Ayres, Mrs. K. D. 2210 Meridian
Benoit, Mrs. M. 1504 Crystal
Blassaras, Mrs. C. A. 2018 Mounds
Brock, Mrs. E. E. Madison Hts.
Buckles, Mrs. D. L. 233 W. 8th
Conrad, Mrs. E. M. 2124 Meridian
Drake, Mrs. John C. Madison Hts.
Ellis, Mrs. Seth W. 335 W. 5th
Erehart, Mrs. A. D. 1221 Irving
Fischer, Mrs. Warren E.
Grandview Terrace
Gante, Mrs. H. W. 2005 Nichol
Guthrie, Mrs. F. C. 2205 Nichol
Hart, Mrs. Wm. D. 1026 W. 8th
Hensler, Mrs. B. M. Edgewood Add.
Jones, Mrs. A. T. 1930 W. 12th
Kelly, Mrs. Wendell C.
R. R. 8, Edgewood Add'n
King, Mrs. Bernard A.
Edgewood Addn.
King, Mrs. Jos. W. Edgewood Add.

MADISON COUNTY
(Anderson—Continued)

Larmore, Mrs. J. L. Edgewood Add.
Litzenberger, Mrs. Sam W.
Forest Hills
Long, Mrs. Paul L. Forest Hills
Metcalf, Mrs. Geo. B. 830 W. 8th
Neale, Mrs. Alfred E. 630 Madison
Nesbit, Mrs. L. L. 8th St. Rd.
Patterson, Mrs. W. K. 2747 Nichol
Polhemus, Mrs. W. C. 1800 W. 11th
Rosenbaum, Mrs. L. E. Forest Hills
Ross, Mrs. Guy E. Madison Hts.
Rozelle, Mrs. C. V. Forest Hills
Stamper, Mrs. Joseph
R. R. 7, Box 47
Swan, Mrs. R. C. Forest Hills
Webb, Mrs. H. D. Edgewood Addn.
Wilder, Mrs. G. B. 338 W. 8th
Williams, Mrs. R. H. 1907 W. 10th
Wilkinson, Mrs. Roger L.
Edgewood Addition
Willson, Mrs. C. 2003 Meridian
Wishard, Mrs. F. B. 905 W. 9th
York, Mrs. F. A. State Rd. No. 32

Drake, Mrs. Marion C. Elwood
Scea, Mrs. Wallace A. Elwood
Bishop, Mrs. Harry A. Frankton
Elsten, Mrs. Wayne A. Lapel
Williams, Mrs. R. D. Markleville
McLaughlin, Mrs. C. P. Pendleton
Williams, Mrs. F. M. Pendleton

MARION COUNTY

Ramage, Mrs. Walter F.
244 S. 1st, Beech Grove
Himebaugh, Mrs. James R. S.
R. R. 2, Box 46A, Greenwood

Indianapolis

A

Adkins, Mrs. Harold C.
250 W. Hampton Dr.
Albertson, Mrs. Frank P.
5031 Rockville Rd.
Aldrich, Mrs. H. D. 3039 Park
Alvis, Mrs. E. O. R. R. 14, Box 203
Arbuckle, Mrs. Russell L.
3716 Watson Rd.
Arbuckle, Mrs. Wm. E.
1759 W. Morris

B

Bachmann, Mrs. A. J. 3239 Winfield
Bakemeier, Mrs. Otto H.
5535 E. St. Clair
Ball, Mrs. Jos. E. 823 N. Lesley
Bartley, Mrs. Max D. 107 E. 48th
Batman, Mrs. Gordon W.
6906 N. Delaware
Bean, Mrs. Jos. S.
1425 N. Berwick
Beasley, Mrs. Thomas J.
112 Berkeley Rd.
Beaver, Mrs. H. W.
R. R. 6, Box 158
Berman, Mrs. J. K.
1105 W. Kessler Blvd.
Bibler, Mrs. L. D. 3821 Guilford
Blatt, Mrs. A. E. 5330 N. Illinois
Bowers, Mrs. D. D.
R. R. 14, Box 240E
Bowman, Mrs. George W.
5634 Carrollton
Boyer, Mrs. E. B. 6024 E. 10th
Boyer, Mrs. F. A. 136 S. Wittfield
Brady, Mrs. T. A. 440 Berkeley Rd.
Brayton, Mrs. John R.
3128 E. Fall Ck. Blvd., N. Dr.
Brodie, Mrs. Donald W.
R. R. 12, Box 24M
Brown, Mrs. Edw. A. 5420 Central
Browning, Mrs. James S.
6146 N. Penn.
Brubaker, Mrs. E. H. 624 E. 23rd
Burdette, Mrs. Harold F.
5733 Broadway
Burghard, Mrs. R. 2171 E. 67th

C

Cahn, Mrs. Hugo M. 3038 Park
Call, Mrs. Herbert F. 710 E. 57th
Campbell, Mrs. John A.
5201 Grandview Dr
Carson, Mrs. E. W.
7177 N. Meridian
Carter, Mrs. L. D.
4280 N. Meridian
Carter, Mrs. Oren E. 5461 Kenwood
Clark, Mrs. Lawson J.
2425 E. Kessler Blvd.
Conley, Mrs. Jos. L. 1617 E. Ohio
Conway, Mrs. Glenn
2235 E. Garfield Dr.
Cornacchione, Mrs. M.
5703 Broadway Terrace
Cortese, Mrs. J. V. 1421 N. Tuxedo
Cortese, Mrs. Thomas A.
3240 Brill Rd.
Cox, Mrs. C. E. R. R. 16, Box 593
Craven, Mrs. H. T. 730 E. 52nd
Cuthbert, Mrs. Marvin
5611 N. Delaware

D

Davidson, Mrs. N. Cort
3135 N. Delaware
Davis, Mrs. Sam J. 5114 Park
Day, Mrs. Clark 29 W. 42nd
Dearmin, Mrs. Robert M.
5147 N. Delaware
DeArmond, Mrs. Murray
5401 N. Delaware
Deever, Mrs. John W. 4160 Madison
Denny, Mrs. James W.
84 N. Audubon Rd.
Donato, Mrs. A. M. 4225 S. East
Donner, Mrs. Paul 1832 E. 10th
Dorman, Mrs. W. Leland
R. R. 9, Box 157
Dugan, Mrs. William M.
5747 Rolling Ridge Rd.
Dunbar, Mrs. Colin V.
3615 Watson Rd.
Dunning, Mrs. L. M. 5435 N. Penn.
Dyar, Mrs. E. W. 5910 Wash. Blvd.

E

Eastman, Mrs. Jos. Rilus, Sr.,
8160 N. Meridian
Eastman, Mrs. J. R., Jr.
8217 Spring Mill Rd.
Eaton, Mrs. Edwin R. 3037 Park
Eberwein, Mrs. John H.
414 E. Fall Creek Pkwy., N. Dr.
Egbert, Mrs. Herbert L.
3210 Washington Blvd.
Eicher, Mrs. Palmer 4902 Park
Eldridge, Mrs. G. E. 5746 Central
Ellis, Mrs. Bert E.
R. R. 2, Box 438H
Emhardt, Mrs. J. T. 3305 Brill Rd.
Emhardt, Mrs. John William
5424 Washington Blvd.
Evans, Mrs. Paul V. 5725 Indianola
Everly, Mrs. Ralph 1105 E. 58th

F

Fausset, Mrs. Basil 5236 Graceland
Flanigan, Mrs. M. B. 2920 W. 33rd
Flora, Mrs. J. O. 5604 Rockville Rd.
Folkening, Mrs. N. O. 5501 Camden
Foreman, Mrs. Harry L.
3835 Washington Blvd.
Fouts, Mrs. Paul J. 8391 N. Illinois
Fromhold, Mrs. W. A. 5514 Manker
Fry, Mrs. Robt. D. 5717 Broadway

G

Gabe, Mrs. William E.
502 W. Hampton Dr.
Gambill, Mrs. William D.
R. R. 17, Box 66
Garber, Mrs. J. Neill
4535 Marcy Lane
Garceau, Mrs. Geo. J. 4334 N. Penn.
Gardiner, Mrs. Sprague H.
46 W. 52nd St.
Gardner, Mrs. Buckman
315 W. Hampton Dr.
Garrett, Mrs. John D.
2523 Central, No. 2
Garrett, Mrs. Robert A.
5022 Winthrop Ave.
Gaskill, Mrs. H. S. 4528 College
Gastineau, Mrs. Frank M.
5344 N. Penn. St.
Geider, Mrs. Roy A.
5816 Pleasant Run Pkwy.
George, Mrs. Charles 1121 E. 80th
Gick, Mrs. H. H. 451 Eastern Ave.
Gifford, Mrs. Fred E.
5125 N. Meridian
Gillespie, Mrs. C. F. 2615 E. 35th
Goldman, Mrs. Sam 5632 Rosslyn
Gosman, Mrs. Jas. H. 340 E. Maple
Gramling, Mrs. Joseph J.
4209 N. Capitol Ave.
Graves, Mrs. John W.
949 Ellenberger Pkwy., E. Dr.
Greist, Mrs. John H.
5032 Park Ave.
Griffith, Mrs. R. S. 1676 Winton
Griffith, Mrs. R. E.
4452 Wash. Blvd.
Grisell, Mrs. Ted L. 3237 Winthrop
Gustafson, Mrs. Gerald W.
5768 N. Penn.

H

Habich, Mrs. Carl. 4335 Broadway
Hadley, Mrs. David
3132 N. New Jersey
Haggard, Mrs. E. B.
3481 Birchwood Ave.
Hahn, Mrs. E. V. R.R. 2, Box 529
Hall, Mrs. Frank 6909 College
Hall, Mrs. Jack R. 3542 Kenwood
Hampshire, Mrs. Donald
4378 Central
Hamer, Mrs. Homer 4454 N. Penn.
Hanna, Mrs. T. A. 5009 W. 15th
Hansell, Mrs. R. M.
3525 N. Gladstone
Hansell, Mrs. Robert M.
3523 N. Gladstone
Harcourt, Mrs. A. K. 4915 N. Ill.
Harding, Mrs. M. R. 2830 W. 33rd
Harding, Mrs. M. S. 46 W. 46th
Harold, Mrs. Albert H.
7510 Allisonville Rd.

MARION COUNTY

(Indianapolis—Continued)

Harold, Mrs. N. E. . . . 653 W. 30th
Haslinger, Mrs. C. J.
5236 Boulevard Pl.
Hawk, Mrs. J. H. . . 4249 Broadway
Haymond, Mrs. Jos. L. 551 E. 36th
Hays, Mrs. E. L. . . . . 2607 Manker
Hedrick, Mrs. Philip . . . 652 E. 54th
Helmer, Mrs. O. M. 5015 N. Illinois
Hendricks, Mrs. J. W. . . 124 W. 64th
Hepburn, Mrs. C. K.
R. R. 14, Box 187L
Hetherington, Mrs. A. M.
5224 Pleasant Run Blvd., N. Dr.
Hetherington, Mrs. John
445 E. 71st
Heubi, Mrs. J. E. . . . 5061 N. Illinois
Hickman, Mrs. W. F. 5125 N. Penn.
Hippensteel, Mrs. Russell
7780 N. Penn.
Hoag, Mrs. W. I. . . . 2627 W. Wash.
Holman, Mrs. James E., Sr.
R. R. 13, Box 73
Hood, Mrs. A. A. . . . . 1444 W. 25th
Horwitz, Mrs. Thos. 2158 Admiral
Howell, Mrs. Jos. . . 3431 Winthrop
Howell, Mrs. R. D. . . . . 930 E. 56th
Hudson, Mrs. Foster J.
525 W. Hampton Dr.
Hughes, Mrs. J. E. 1628 Carrollton
Hughes, Mrs. W. F., Sr.
4025 N. Meridian

I-J

Irwin, Mrs. G. W., Jr.
5022 Graceland
Iske, Mrs. Paul G. . 5244 N. Penn.
Jaeger, Mrs. Alfred S.
2935 Washington Blvd.
Jaquith, Mrs. O. S.
261 Blue Ridge Rd.
Jay, Mrs. Arthur N.
4319 Kingsley Dr.
Jenkins, Mrs. R. E. . . . . 36 E. 57th
Jennings, Mrs. Frank
Sunnyside Sanatorium
Jewett, Mrs. J. H. . . . . 4907 Rosslyn
Jinks, Mrs. C. H. . . . 5740 Carrollton
Johnson, Mrs. Thomas W.
5737 Washington Blvd.
Jones, Mrs. D. E. . . 646 Berkley Rd.
Joseph, Mrs. Rex M. . . . 624 Lincoln

K

Kammen, Mrs. Leo . . . . 237 W. 46th
Katterjohn, Mrs. Jas. . . 102 E. 50th
Kauffman, Mrs. N. N. 5970 Central
Keenan, Mrs. Reid L.
3702 N. Delaware
Kelly, Mrs. John F. 5464 N. Capitol
Kelly, Mrs. Walter F.
6845 E. Pleasant Run Pkwy.
Kelly, Mrs. Wm. M. 3308 N. Euclid
Kempf, Mrs. Gerald F.
2605 E. Riverside
Kennedy, Mrs. Hunter
757 N. Bolton
Kerr, Mrs. Harry R.
5774 Washington Blvd.
Kilgore, Mrs. B. W.
3351 N. Wallace
Kime, Mrs. Edwin N.
239 Buckingham Dr.
Kingsbury, Mrs. John K.
5776 E. Michigan
Kirklin, Mrs. O. L.
8005 Englewood Rd.
Kiser, Mrs. Edgar F. . 5610 Central
Kitterman, Mrs. Harry E.
5108 Graceland
Knowles, Mrs. C. Y.
1121 N. Downey
Kohlstaedt, Mrs. K. G.
R. R. 14, Box 253
Kornafel, Mrs. L. H. . . 6201 College
Kraft, Mrs. Bennett
7025 Washington Blvd.
Kuntz, Mrs. H. W. . . . 823 Weghorst
Kurtz, Mrs. Philip L. . . 6841 Willow
Kwitney, Mrs. I. J.
5774 Broadway Ter.

L

LaDine, Mrs. C. B. . . . . 4221 E. 35th
Lamb, Mrs. Emmett B.
1180 Golden Hill Dr.
Lamb, Mrs. R. W. . . 4636 N. Capitol
Lamber, Mrs. Chet K.
1501 E. Maple Rd.
Larkin, Mrs. Bernard J.
3103 N. Meridian
Lawler, Mrs. George F.
5601 E. St. Clair
Leasure, Mrs. J. Kent
3115 N. Meridian
Leff, Mrs. A. H. . . 6344 Wash. Blvd.
Leonard, Mrs. H. S. . . 4123 E. 38th
Levi, Mrs. Leon
402 W. Hampton Dr.
Lewis, Mrs. R. J. . . . 3742 N. Denny
Lichtenberg, Mrs. Melvin
4021 N. New Jersey
Lingeman, Mrs. R. E. 2334 E. 58th
Link, Mrs. Goethe 3015 N. Meridian
Littell, Mrs. J. J. . . . . 3619 N. Penn.
Loehr, Mrs. Wm. M.
6044 Crittenden
Lochry, Mrs. R. L.
6150 Crows Nest Dr.
Loomis, Mrs. N. S. . 5230 Kenwood
Lord, Mrs. Glen C.
4455 Washington Blvd.
Lorman, Mrs. J. G.
2645 Cold Spring Lane
Ludwig, Mrs. O. D. . 5433 Madison
Lybrook, Mrs. Wm. B.
3636 N. Keystone

M

McBride, Mrs. J. S. . 7048 Warrick
McCaskey, Mrs. Carl H.
3545 Washington Blvd.
McCown, Mrs. P. E.
5008 N. Meridian
McDevitt, Mrs. D. R. 5470 Guilford
McGrath, Mrs. M. F.
6183 Wash. Blvd.
McGuff, Mrs. Paul . . . . 3545 College
McIntire, Mrs. C. R.
1726 N. Meridian
McQuiston, Mrs. R. J.
R. R. 15, Box 335
McTurnan, Mrs. Robert W.
5957 Kingsley Dr.
MacDonald, Mrs. John A.
1408 N. Penn.
MacGregor, Mrs. Donald E.
6080 N. Michigan Rd.
Mackey, Mrs. J. E. . . . . 629 E. 32nd
Magennis, Mrs. H. L.
3010 E. 38th, No. 14
Manion, Mrs. Marlow W.
5132 N. New Jersey
Mann, Mrs. Mortimer . . 28 E. 55th
Manning, Mrs. J. C. . . . 3121 Sharon
Marshall, Mrs. Cavins R.
6120 N. Michigan Rd.
Martin, Mrs. L. H. . . . 5069 W. 15th
Martz, Mrs. Carl D.
4571 Fall Creek Blvd., S. Dr.
Masters, Mrs. John M. . . . 34 E. 46th
Matthew, Mrs. Burleigh W.
3462 E. Fall Creek Blvd.
Matthews, Mrs. Wm.
943 N. Franklin Rd.
Megenhardt, Mrs. Dennis
3038 E. Fall Creek Pkwy.
Meiks, Mrs. L. T. . . . . 4203 N. Penn.
Mericle, Mrs. Earl W.
4480 N. Meridian
Merrell, Mrs. Paul
270 Buckingham Dr.
Mertz, Mrs. Henry O.
721 Clarendon Pl.
Micheli, Mrs. Arthur J.
3453 N. Penn, No. 1
Miller, Mrs. Milton 1445 N. Dela.
Miller, Mrs. R. S. . . . . 6140 College
Mitchell, Mrs. Earl H.
2263 E. Riverside Dr.
Moenning, Mrs. W. P.
7030 N. Penn.
Molt, Mrs. Wm. F. . . 2315 N. Talbot
Montgomery, Mrs. W. F.
246 W. 54th
Moore, Mrs. H. S. . . . 3220 Sharon
Moore, Mrs. R. M. 5617 N. Meridian
Morchan, Mrs. Samuel
3116 E. 39th
Morrison, Mrs. L. E. . 3460 Winthrop
Morton, Mrs. Walter P.
3434 E. Fall Creek Blvd.
Moser, Mrs. Rollin H.
R.R. 16, Box 707
Muller, Mrs. P. F. . . . . 4329 Park
Myers, Mrs. R. V.
R. R. 13, Box 75

N

Nafe, Mrs. Cleon 5060 N. Meridian
Nay, Mrs. Richard M. . . . . 4163 Park
Need, Mrs. Lewis T.
R. R. 19, Box 562
Nehil, Mrs. Lawrence W.
257 W. Westfield Blvd.
Nie, Mrs. Louis W. . . . 4305 Central
Noble, Mrs. Thomas B., Jr.
4360 N. Penn.
Noe, Mrs. Wm. R.
5167 Otherton, S. Dr.
Nolting, Mrs. Henry F.
155 W. Hampton Dr.
Norman, Mrs. Wm. H.
6416 Dean Rd.
Nourse, Mrs. Myron 5251 Primrose
Nugent, Mrs. Edwin J.
2266 Wyndale Rd.

O

Ochsner, Mrs. H. C. . . . . 405 E. 45th
Olvey, Mrs. O. N. . 5533 Broadway
Otten, Mrs. Claude F. 4456 Central
Ottinger, Mrs. Ross C.
5720 Sunset Lane
Owen, Mrs. John E. 4429 N. Illinois
Owens, Mrs. Tracy
2823 N. Meridian

MARION COUNTY
(Indianapolis—Continued)

P-Q

Pandolfo, Mrs. Harry
529 Markwood Ave.
Patton, Mrs. M. T.
3060 N. Meridian, No. 504
Paulissen, Mrs. G. T....310 E. 24th
Paynter, Mrs. Morris B..Robert Rd.
Pearson, Mrs. Lyman R.
5338 Washington Blvd.
Peck, Mrs. F. B.....5826 Winthrop
Pennington, Mrs. W. E.
4420 N. Meridian
Permer, Mrs. Erwin
3018 N. Delaware
Peters, Mrs. Robert J. D.
3203 E. Michigan
Petranoff, Mrs. T. B..3367 W. Mich.
Pilcher, Mrs. Jack E.
4601 Graceland
Pollak, Mrs. Lewis...5658 Guilford
Powell, Mrs. H. M., Jr.
Highfall Rd., Brendenwood
Pryor, Mrs. R.....6134 Carrollton

R

Raber, Mrs. Robt...6063 Haverford
Rader, Mrs. Geo. S...3778 E. 62nd
Ramsey, Mrs. Frank
R. R. 17, Box 161
Reed, Mrs. Philip B.
4131 N. Meridian
Rees, Mrs. R. C.
926 Ellenberger Pkwy., N. Dr.
Reid, Mrs. Chas. A...6512 Madison
Rice, Mrs. Raymond 5365 N. N. J.
Ricketts, Mrs. J. W..5349 Kenwood
Rigg, Mrs. J. P....515 N. Meridian
Ritchey, Mrs. Jas. O.....43 W. 43rd
Robb, Mrs. John A..5254 Broadway
Roller, Mrs. C. W..2301 Garfield Dr.
Romberger, Mrs. F. T., Jr.
370 W. 52nd
Rosenak, Mrs. B. D.....325 E. 45th
Ross, Mrs. Alexander T.
265 W. Westfield Blvd.
Row, Mrs. D. Hamilton
5214 Grandview Dr.
Ruddell, Mrs. Karl R.
2626 N. Meridian
Rudolph, Mrs. S. J...3421 Kinnear
Rupel, Mrs. Ernest..5716 N. Penn.
Rust, Mrs. B. K...R. R. 14, Box 214
Ryan, Mrs. Glen V.
3168 E. Fall Ck. Pkwy, N. Dr.

S

Sage, Mrs. Russell A.
R. R. 16, Box 468
Salb, Mrs. Max.....1116 N. Penn.
Sanders, Mrs. Harry M.
3443 N. DeQuincey
Schechter, Mrs. John
4966 Kingsley Dr.
Schneider, Mrs. C. J.
340 N. Kenyon
Schuchman, Mrs. G.. 5944 Central
Schuster, Mrs. Dwight
5042 Capitol
Seaman, Mrs. C. F.....3954 Ruckle
Sexson, Mrs. H. T.....401 W. 46th
Shafer, Mrs. M. R.
6390 Allisonville Rd.
Sheehan, Mrs. F. G.....950 Graham
Shugart, Mrs. Jos. A..2620 E. 37th
Shullenberger, Mrs. W. A.
4535 Central
Shumacker, Mrs. H. B.
4330 Central
Sicks, Mrs. Okla W...5609 N. Penn.
Siekerman, Mrs. C. W.
1604 Loretta
Sigmond, Mrs. H. W..3245 N. Penn.
Sims, Mrs. J. L.....3723 N. Gale
Sluss, Mrs. David 3657 Wash. Blvd.
Smith, Mrs. Lester A.
126 Berkeley Rd.
Smith, Mrs. Roy Lee
R. R. 6, Box 473
Solomon, Mrs. R. A..5330 N. Penn.
Sovine, Mrs. J. W...5311 N. Illinois
Spahr, Mrs. John F., Jr.
3845 N. Meridian
Sparks, Mrs. Alan L...4310 Central
Sputh, Mrs. C. B., Jr..3662 N. Gale
Sputh, Mrs. Carl B., Sr.
5735 Central
Stadler, Mrs. H. E.
6244 Wash. Blvd.
Stayton, Mrs. Chester A., Sr.
5876 Central
Steffy, Mrs. R. M..354 N. Jefferson
Stephens, Mrs. Donald
5555 Broadway
Steven, Mrs. S. Gloria Spink Arms
Stevens, Mrs. Sydney L.
3420 N. Temple
Stone, Mrs. A. T....5727 Broadway
Stone, Mrs. D. F...5603 Indianola
Stroup, Mrs. T. J.....5758 College
Stucky, Mrs. E. K..3602 Watson Rd.
Stygall, Mrs. J. H.
4311 N. Meridian
Sudranski, Mrs. Herbert F.
3614 Guilford
Sutton, Mrs. W. E...5670 Guilford
Swan, Mrs. J. R..5402 N. Delaware
Szynal, Mrs. J. S.....1841 Warman

T

Tanner, Mrs. Henry S.
5144 N. Delaware
Taylor, Mrs. Clifford M.
5938 Crittenden
Taylor, Mrs. F. W.....40 E. 43rd
Teague, Mrs. Frank W.
R. R. 14, Box 216
Tether, Mrs. J. Edward
2206 Lafayette Rd.
Tharp, Mrs. Howard
5302 E. St. Clair
Tharpe, Mrs. Ray....Marott Hotel
Thatcher, Mrs. Hugh K., Jr.
745 W. 44th
Thomas, Mrs. Lowell
28 W. Hampton Dr.
Thomas, Mrs. Morris E.
5207 N. New Jersey
Thompson, Mrs. Charles E.
6038 N. Olney
Thompson, Mrs. John V.
R. 14, Box 122T
Thornburg, Mrs. K. E.
4702 Wash. Blvd.
Thurston, Mrs. A. L....421 E. 41st
Tinney, Mrs. W. E..3902 Carrollton
Tinsley, Mrs. Walter B.
3314 Carrollton
Torrella, Mrs. J. A....4918 W. 14th
Trusler, Mrs. Harold M.
6150 N. Penn.
Tuchman, Mrs. J. N..4525 Indianola
Tucker, Mrs. R. L...5075 Norwaldo

V

Vandivier, Mrs. R. M.
4732 Cornelius
VanMeter, Mrs. C. Powell
1925 N. Emerson
VanOsdol, Mrs. H. A.
43 Hampton Dr.
VanTassel, Mrs. C. J., Jr.
521 E. 60th
Voyles, Mrs. Charles F.
4150 N. Meridian

W

Waldo, Mrs. J. T....8383 N. Illinois
Walker, Mrs. Frank C.
5563 N. Penn.
Walther, Mrs. Joseph E.
4266 N. Penn.
Warvel, Mrs. J. H....R. 17, Box 312
Waterman, Mrs. John H.
5435 N. Capitol
West, Mrs. J. L. 5261 Woodside Dr.
Westfall, Mrs. B. K., Jr.
6601 College
Westfall, Mrs. J. B....3618 E. 34th
White, Mrs. Donald J.
5430 N. Delaware
Whitehead, Mrs. J. M.
2201 Nowland
Whitlock, Mrs. Irvin
4816 Pl. Run Pkwy.
Whitlock, Mrs. F. C. 901 N. Leland
Wilkens, Mrs. I. W.
4816 Pleasant Run Pkwy.
Williams, Mrs. Howard
3908 Guilford
Williams, Mrs. Hugh L.
4907 Guilford
Wilmore, Mrs. R. C..6015 Evanston
Wilson, Mrs. O. R.
3519 Wash. Blvd.
Winters, Mrs. Mathew
4044 Carrollton
Wishard, Mrs. W. N., Jr.
4150 N. Illinois
Wise, Mrs. Wm.....4934 N. Penn.
Wolfe, Dr. Ernest...1236 N. Penn.
Wolfram, Mrs. D. J 5872 Broadway
Wright, Mrs. J. W. Jr.,
2115 Wilshire Rd.
Wyttenbach, Mrs. J. E.
5509 Kenwood

Y-Z

Young, Mrs. J. M. 4525 Marcy Lane
Young, Mrs. J. W...5815 Primrose
Young, Mrs. W. C....3215 Medford
Zell, Mrs. E. H.....4624 Norwaldo

Stephens, Mrs. K. H.....Lawrence
Miller, Mrs. R. D.....Martinsville

New Augusta

Asher, Mrs. Ernest O.....Box 4
Brown, Mrs. David....Lakeside Dr.
Brown, Mrs. Dewitt, Jr....W. 86th
Harris, Mrs. C. B.
R.R. 1, Box 375A
Talbott, Mrs. D. E.
6602 N. Mich. Rd.

Browning, Mrs. W. M.
5039 W. 13th, Speedway City
Burkhardt, Mrs. Boyd
328 N. West St., Tipton
Jones, Mrs. Geo. L.....Wanamaker
Bailey, Mrs. L. S.....Zionsville

MARSHALL COUNTY

Graham, Mrs. C. R.....Bourbon
Bowen, Mrs. Otis R.....Bremen
Witham, Mrs. R. L.....Culver

Plymouth

Knott, Mrs. Harry
1017 N. Michigan
Kubley, Mrs. James..201 Dickson
Pomeroy, Mrs. R. K.....1400 Park

MIAMI COUNTY

Line, Mrs. Homer.....Chili
Frybarger, Mrs. S. S.....Converse
Sennett, Mrs. Wm. K.....Macy
Waite, Miss Carrie.....Macy
Waite, Miss Margaret.....Macy
Rendel, Mrs. C. F.....Mexico
Rendel, Mrs. H. E.....Mexico

Peru

Andrews, Mrs. E. H...172 W. Third
Askue, Mrs. Paul....352 W. Blvd.
Baldwin, Mrs. C. F.
17½ S. Huntington Rd.
Barnett, Mrs. Helen...65 N. Miami
Berkebile, Mrs. J. B.....15 W. 6th
Carl, Mrs. Omer.....128 W. Third
Eikenberry, Mrs. B. F....28 W. 6th
Freezee, Mrs. J. A.....212 E. Main
Johnson, Mrs. O. B.....563 W. 6th
Malouf, Mrs. S. D.....359 W. Third
McDowell, Mrs. Anna 53 E. Second
Wagner, Mrs. M. L.....R. R. 4
Wildman, Mrs. R. E.....R. R. 2
Yarling, Mrs. Francis..117 E. Fifth

MONTGOMERY COUNTY

Crawfordsville

Alexander, Mrs. S. J.....202 West
Ball, Mrs. T. Z.....401 S. Wash.
Burks, Mrs. J. E.....411 S. Walnut
Cooksey, Mrs. T. L....206 Marshall
Cornell, Mrs. R. A....521½ E. Main
Daugherty, Mrs. F. N..415 W. Main
Griffith, Mrs. J. B.....218 S. Green
Haller, Mrs. T. C.....508 W. Main
Humphreys, Mrs. J. W.
206 Woodlawn
Kinnaman, Mrs. H. A.
1107 W. Wabash
Kirtley, Mrs. J. M.....201 S. Grant
Lingeman, Mrs. B. J...203 Wallace
Millis, Mrs. R. J.....8 Mills Place
Mount, Mrs. W. M...1417 W. Main
Pierson, Mrs. R. H.....305 E. Main
Peacock, Mrs. N. F..107 Vernon Ct.
Pollom, Mrs. R. R.....506 S. Water
Sharp, Mrs. J. L.....1403 E. Main
Taylor, Mrs. W. M...410 S. Water
Wallace, Mrs. H. C.
107 W. Jefferson

Otten, Mrs. R. R.....Darlington
Preibe, Mrs. Fred.....Hillsboro
Schaaf, Mrs. Alvin R...Jamestown
Smith, Mrs. B. J.....Kingman
Blix, Mrs. Fred.....Ladoga
Denny, Mrs. F. T.....Ladoga
Walterhouse, Mrs. H. H....Ladoga
Davis, Mrs. W. H.....New Market
Kindell, Mrs. H. D..New Richmond
Gwaltney, Mrs. L. F.....Roachdale
Richards, Mrs. E. E....Russellville
Himebaugh, Mrs. G. J.Veedersburg
Rusk, Mrs. H. M.....Wallace
Hendricks, Mrs. Claude..Waveland
Johnson, Mrs. Dale....Waynetown
Parker, Mrs. C. B.....Wingate

MORGAN COUNTY

Martinsville

Dickens, Mrs. Karl..95 W. Jackson
Eisenberg, Mrs. David
340 E. Cunningham
Gray, Mrs. Leon.....260 N. Ohio
Pitkin, Mrs. Edw.....309 E. Wash.
Pitkin, Mrs. McKendree
440 E. Wash.
Sweet, Mrs. A. D....260 N. Wayne
Willan, Mrs. H. R...109 S. Jefferson

Comer, Mrs. Chas.....Mooresville
Comer, Mrs. Kenneth..Mooresville
VanBokkelen, Mrs. R. W.
Mooresville

NORTHEASTERN ACADEMY

Bowman, Mrs. Chas.....Albion
Morr, Mrs. J. W.....Albion
Nash, Mrs. J. R.....Albion
Barton, Mrs. Robt.....Angola
Rausch, Mrs. Norman.....Angola
Thill, Mrs. L. J.....Ashley
Nugen, Mrs. Harold.....Auburn
Rogers, Mrs. E. E.....Auburn
Sanders, Mrs. J. A.....Auburn
Sneary, Mrs. K. D.....Avilla
Hathaway, Mrs. C. B.....Butler
Weirich, Mrs. C. I.....Butler
Jinnings, Mrs. L. B.....Garrett
Kantzer, Mrs. F. B.....Garrett
Reynolds, Mrs. D. M.....Garrett
Reynolds, Mrs. Perry.....Garrett
Alford, Mrs. James.....Hamilton
Wade, Mrs. A. A.....Howe
Gutstein, Mrs. R. R....Kendallville
Hardy, Mrs. F. C.....Kendallville
Lawson, Mrs. I. H.....Kendallville
Munk, Mrs. C. E.....Kendallville
Seybert, Mrs. J. D.....Kendallville
Williams, Mrs. H. O....Kendallville
Schutt, Mrs. J. B.....Ligonier
Stultz, Mrs. Q. F.....Ligonier
Fipp, Mrs. A. L.....Rome City
Coleman, Mrs. Floyd.....Waterloo
Showalter, Mrs. J. R.....Waterloo
Pulskamp, Mrs. B. H..Wolcottville
Luckey, Mrs. R. C.....Wolf Lake

OWEN-MONROE COUNTIES

Bloomington

Austin, Mrs. Rayburn.114 S. Grant
Baxter, Mrs. Neal....515 N. Wash.
Borland, Mrs. Ray....Moores Pike
Buckingham, Mrs. Richard
705 S. Fess
DeMotte, Mrs. R. A.
904 S. Rose Ave.
Estes, Mrs. Ambrose
521 S. Mitchell
Fowler, Mrs. Richard
807 S. Henderson
Geiger, Mrs. Dillon....N. Fee Lane
Holland, Mrs. D. J...313 N. College
Holland ,Mrs. Chas...712 N. Wash.
Holland, Mrs. Frank.514 N. College
Holland, Mrs. J. E. P.
514 N. College
Karsell, Mrs. W. A.
700 Highland Ave.
Lyons, Mrs. Robert..Unionville Rd.
Marchant, Mrs. Clarence
350 S. College
Middleton, Mrs. Thos.
404 E. Seventh
Myers, Mrs. B. D....424 N. Walnut
Poolitson, Mrs. Geo.
619 E. Ninth
Prosser, Mrs. Wm....1211 Maxwell
Quarles, Mrs. E. B.
811 S. Woodlawn
Ramsey, Mrs. Hugh...619 E. First
Reed, Mrs. Wm.....1215 Atwater
Rogers, Mrs. Floyd..804 E. Eighth
Ross, Mrs. Ben....Martinsville Rd.
Schell, Mrs. H. D....801 E. Eighth
Smith, Mrs. Herschel
Martinsville Rd.
Spencer, Mrs. Beaufort..816 E. 8th
Stangle, Mrs. Wm...1818 E. Third
Thomas, Mrs. Harry.1717 E. Third
Topolgus, Mrs. Jas...603 N. Walnut
Wilson, Mrs. T. L..301 E. Kirkwood

Smith, Mrs. Paul.....Ellettsville
Stouder, Mrs. Chas.....Gosport
Brown, Mrs. Marcel
358 Wash. St., Spencer
Smith, Mrs. F. R.
448 Lovers Lane, Spencer
Mitchell, Mrs. G. L.....Smithville

PARKE-VERMILLION COUNTIES

Green, Mrs. Fred....Bloomingdale
Brown, Mrs. R. E.....Cayuga
Casebeer, Mrs. Paul B.....Clinton
Evans, Mrs. F. J.....Clinton
Gerrish, Mrs. W. D.....Clinton
Kercheval, Mrs. J. M.....Clinton
Rosenfeld, Mrs. N. B.....Clinton
White, Mrs. I. D.....Clinton
Myers, Mrs. W. C.....Dana
Warren, Mrs. Bradford...Marshall
Britton, Mrs. W. D.....Montezuma
Saunders, Mrs. J. L.....Newport
Johnson, Mrs. W. A.....Perrysville
Bloomer, Mrs. J. R.....Rockville
Bloomer, Mrs. R. S.....Rockville
Dowell, Mrs. Emil.....Rockville
Harstad, Mrs. C.....Rockville
Merrell, Mrs. B. M.....Rockville
Pirkle, Mrs. H. B.
State San., Rockville
Staff, Mrs. R. A.
State San., Rockville
White, Mrs. C. S.....Rosedale
Keith, Mrs. F. E.....St. Berneice

PERRY COUNTY

Bush, Mrs. H. R..6th St., Cannelton

Tell City

Dome, Mrs. H. S.....147 Eleventh
Dukes, Mrs. D. A.....521 Main
Coultas, Mrs. P. J.....809 Main
Glenn, Mrs. F. C.....436 Main
James, Mrs. N. A.....740 Ninth
Lashley, Mrs. D. L.....600 Ninth
Lally, Mrs. B. V.....622 Main
Neifert, Mrs. N. L.....S. Blum

Snyder, Mrs. Earl L.....Troy

PORTER COUNTY

Chesterton

Griffin, Mrs. J. F. ..... 134 Park
Hall, Mrs. T. C. ..... 600 E. Morgan

Valparaiso

Brown, Mrs. J. C. ..... 458 Park
Davis, Mrs. C. E. ..... 202 Indiana
DeGrazia, Mrs. E. G. .. 157 McIntyre
Douglas, Mrs. G. R. ..... 404 Wash.
Eades, Mrs. Ralph
501 E. Lincolnway
Makovsky, Mrs. Theodore
909 Institute
Miller, Mrs. E. H. ..... 608 Union
Seipel, Mrs. H. O. ... 302 Lafayette
Vietzke, Mrs. P. C. F. ... 58 Jefferson

PULASKI-STARKE COUNTIES

Ferguson, Mrs. J. F. ..... Hamlet
Downey, Mrs. R. M. ..... N. Judson
Farabee, Mrs. C. R. ..... N. Judson
Fisher, Mrs. Nora ..... N. Judson
Matthews, Mrs. J. R. ..... N. Judson
Carneal, Mrs. T. E. ..... Winamac
Halleck, Mrs. H. J. ..... Winamac
McCaskey, Mrs. G. H. ..... Winamac
Thompson, Mrs. W. R. .... Winamac

PUTNAM COUNTY

Veach, Mrs. L. W. ..... Bainbridge
Veach, Mrs. Richard .... Bainbridge
Gray, Mrs. Clyde ..... Cloverdale

Greencastle

Detloff, Mrs. F. R. .. 201 W. Walnut
Dobbs, Mrs. O. R. ..... R. F. D.
Fuson, Mrs. W. J. ..... Northwood
Huckleberry, Mrs. Carl ... R. R. 2
Hutcheson, Mrs. W. R. ... E. Wash.
Johnson, Mrs. J. B. .. 207 E. Poplar
Parker, Mrs. Geo. F. ..... R. F. D.
Rhea, Mrs. G. D. ..... 126 E. Wash.
Schauwecker, Mrs. C. M.
309 Greenwood
Steele, Mrs. Dick ..... Northwood
Tennis, Mrs. George .... S. Jackson
Tipton, Mrs. Wm. R.
203 Northwood
Wiseman, Mrs. V. E. ... Durham St.

Gwaltney, Mrs. L. F. .... Roachdale

RIPLEY COUNTY

Lippoldt, Mrs. C. L. ..... Batesville
Obery, Mrs. George ..... Batesville
Conrad, Mrs. Henry ..... Milan
Hunter, Mrs. G. L. ..... Milan
Daley, Mrs. E. ..... Oldenburg
Row, Mrs. George ..... Osgood
Smith, Mrs. L. R. ..... Osgood
McConnell, Mrs. Wm. .... Sunman
Hopkins, Mrs. L. H. .... Versailles
Moran, Mrs. N. D. ..... Versailles

RUSH COUNTY

McNabb, Mrs. G. B. ..... Carthage
Worth, Mrs. C. W. ..... Milroy

Rushville

Atkins, Mrs. C. C. .. 401 N. Perkins
Corpe, Mrs. K. F. ..... R. R. 4
Dean, Mrs. D. I. ..... 310 E. Fifth
Denny, Mrs. M. H. .. 124 E. Twelfth
Ellis, Mrs. D. W. ..... 543 W. 11th
Frazier, Mrs. John ..... 210½ E. 7th
Green, Mrs. F. H. .... 516 N. Morgan
Johnson, Mrs. Robert
841 N. Harrison
Kennedy, Mrs. R. O. .. 1004 N. Main
Kiplinger, Mrs. Jean
838 N. Harrison
Lee, Mrs. John ..... 914 N. Morgan
Nutter, Mrs. W. H. 1003 N. Morgan
Shanks, Mrs. R. E. . 1110 N. Morgan
Sipes, Mrs. Anna ..... 222 W. Third
Truman, Mrs. Michel
733 N. Morgan

SHELBY COUNTY

Nigh, Mrs. Rufus ..... Fairland
Davis, Mrs. John ..... Flatrock
Miller, Mrs. Frank ..... Morristown

Shelbyville

Barnum, Mrs. Emerson
110 E. Hendricks
Bass, Mrs. F. E. .... 169 W. Wash.
Billman, Mrs. Gus ..... R. R.
Gehres, Mrs. Robt. ..... 610 Shelby
Groves, Mrs. E. G. .. 24 W. Bdwy.
Inlow, Mrs. H. H. ..... N. Harrison
Inlow, Mrs. W. D. .... Springhill Rd.
McFadden, Mrs. Walter
28 W. Mechanic
Miller, Mrs. R. C. ..... W. Mechanic
Phares, Miss Frances .. S. Harrison
Richard, Mrs. Norman ... W. Wash.
Scott, Mrs. V. B. ..... R. R. 2
Silbert, Mrs. David ..... West St.
Spindler, Mrs. Robert
165 W. Mechanic
Tindall, Mrs. Paul 164 W. Franklin
Tindall, Mrs. W. R. 616 S. Harrison
Whitcomb, Mrs. Roger
Smithland Rd.

Inlow, Mrs. Fred ..... St. Paul
Coulson, Mrs. S. B. ..... Waldron

ST. JOSEPH COUNTY

Mishawaka

Barone, Mrs. C. V.
620 Lincolnway E.
Chirstophel, Mrs. W. B.
527 Lincolnway E.
Ganser, Mrs. R. A. .... 409 E. Third
Goethals, Mrs. C. J.
602 Lincolnway W.
Graham, Mrs. H. J. ... 423 W. 3rd
Logan, Mrs. F. W.
304 Lincolnway E.
McDonald, Mrs. R. M.
E. Jefferson Rd.
Martin, Mrs. C. F., Jr.
2125 Linden Ave.
Miller, Mrs. Wm. E.
1020 Wilson Blvd.
Orr, Mrs. W. R. ..... 124 S. Race
Proudfit, Mrs. C. H. .. 1135 E. Third
Rosenwasser, Mrs. Jacob
415 Indiana Ave.
Sirlin, Mrs. E. M.
419 Lincolnway W.
Spalding, Mrs. W. L. .. 617 Webster
Templeton, Mrs. Ames
522 Calhoun
Walters, Mrs. C. E. .... 111 S. Cedar
Ward, Mrs. Jas. W.
316 Lincolnway E.
Whitlock, Mrs. M. E. .... 123 W. 4th
Wurster, Mrs. H. C. .... 221 E. Third
Wyland, Mrs. B. J. .... 510 Calhoun
Zimmer, Mrs. H. J. .. 333 Edgewater

Houser, Mrs. D. S. .. North Liberty

South Bend

Arisman, Mrs. R. K. . 1615 E. Colfax
Balla, Mrs. Morris . 1516 E. Wayne
Bechtold, Mrs. S. E. .... 1825 Wilber
Bennett, Mrs. J. R. . 1072 Woodward
Berke, Mrs. R. D. ..... 2510 Erskine
Biasini, Mrs. B. A.
403 Dixie Hwy., N.
Bickel, Mrs. David A.
1335 E. Wayne, N.
Birmingham, Mrs. P. J.
1126 E. Irvington
Bixler, Mrs. L. C. .... 1817 Portage
Bryan, Mrs. R. J.
519 Harrison Ave.
Buchanan, Mrs. W. D. 1351 E. South
Buechner, Mrs. F. W.
603 W. Marion
Bussard, Mrs. C. F.
329 W. Madison
Bussard, Mrs. F. W.
1332 E. Monroe
Carter, Mrs. F. R. N.
2000 E. Jefferson
Cassady, Mrs. J. V. .. 110 Napoleon
Chambers, Mrs. Wm. R.
1335 E. South
Clark, Mrs. Wm. H.
1336 E. Wayne, N.
Colip, Mrs. G. D. ..... 300 David
Condit, Mrs. D. H.
1521 E. Wayne
Cook, Mrs. G. C. . 1433 Mishawaka
Denham, Mrs. Robt. H.
1429 E. Wayne
Dietl, Mrs. E. L. .. 216 S. Coquillard
Dodd, Mrs. R. D. ..... 1017 Kinyon
Donnelly, Mrs. Everett
R. R. 6, Box 518, Miami Rd.
Duggan, Mrs. J. A. .. 110 Peachway
Dunlap, Mrs. D. L.
123 W. North Shore Dr.
Edwards, Mrs. B. E.
1341 E. Wayne, N.
Egan, Mrs. S. L. . 944 Riverside Dr.
Ellison, Mrs. Alfred Dragoon Trail
English, Mrs. J. P. ..... 1317 Wall
Ericksen, Mrs. G. W.
209 Wildmer Dr.
Erickson, Mrs. L. G.
1322 E. Wayne, N.
Feldman, Mrs. Max
702 N. Lafayette
Filipek, Mrs. W. J.
2513 Lincolnway, W.
Fish, Mrs. C. M. .... 119 Marquette
Fish, Mrs. E. C. .... 1264 E. Colfax
Fisher, Mrs. L. F. .. 1717 E. Colfax
Frank, Mrs. L. L. . 534 N. Lafayette
Frash, Mrs. D. W.
1235 E. Wayne, S.
Frey, Mrs. W. B. .. 338 W. Navarre
Gates, Mrs. G. E.
411 W. North Shore Dr.
Gilman, Mrs. M. M.
2120 E. Jefferson
Godersky, Mrs. Geo. . 2744 Sampson
Goraczewski, Mrs. T. C.
1016 W. Wash.
Green, Mrs. G. F. .... 1515 E. Wayne
Green, Mrs. N. E. .... 1844 Kessler
Grillo, Mrs. Don ... 1832 W. Adams
Hall, Mrs. J. M. R. R. 5, Box 645

ST. JOSEPH COUNTY

(South Bend—Continued)

Hamilton, Mrs. C. O.
1498 Northern
Harmon, Mrs. V. E.
3221 Mishawaka
Haugseth, Mrs. E. K.
410 Manitou Pl.
Helman, Mrs. H. E.
120 W. Franklin
Hewitt, Mrs. M. I.
210 S. Coquillard
Hilbert, Mrs. J. W. 410 W. Wash.
Hillman, Mrs. M. W.
1516 Marquette
Hillman, Mrs. W. H.
1317 Marquette
Hyde, Mrs. C. C. 1521 E. Colfax
Johns, Mrs. N. C. 1329 St. Joseph
Kamm, Mrs. B. A. 1402 E. Wash.
Karn, Mrs. J. W. 425 Napoleon
Klahr, Mrs. E. E. 1422 McKinley
Kramer, Mrs. A. A. 1519 Miami
Lane, Mrs. W. H. 845 Park
Langenbahn, Mrs. C. J.
1339 E. South
Lent, Mrs. E. J. 125 W. Marion
Lindquist, Mrs. N. S.
917 Blaine Ave.
Lionberger, Mrs. J. R.
1224 E. Wayne
Liss, Mrs. Emanuel
1612 E. Madison
Liston, Mrs. Ann
415 St. Joseph Bk. Bldg.
Ludwick, Mrs. H. A. 730 Park Ave.
Mason, Mrs. B. A. 1013 Fox
McCraley, Mrs. W. J.
2420 Erskine
McMeel, Mrs. J. F. 315 E. Corby
Metcalfe, Mrs. G. E.
1209 E. Wayne, N.
Miller, Mrs. M. K. 1714 E. Madison
Mueller, Mrs. H. M.
2802 Beechwood
Murphy, Mrs. E. C.
1411 Sunnymede
Olson, Mrs. K. L.
1228 E. Woodside
Parke, Mrs. D. D. 828 Sorin
Petrass, Mrs. Andrew Liberty Dr.
Pyle, Mrs. H. D. 115 N. Sunnyside
Rigley, Mrs. E. L. 2161 Dixie Hwy.
Rodin, Mrs. H. H. 1138 E. Wayne
Rosenheimer, Mrs. G. M.
1425 E. Woodside
Rubens, Mrs. Eli 1331 E. Victoria
Rudolph, Mrs. C. J.
2016 E. Madison
Sanderson, Mrs. R. B.
1331 Sunnymede
Sandock, Mrs. L. F.
310 S. Sunnyside
Sandoz, Mrs. H. H.
239 S. Hawthorne
Sandoz, Mrs. L. A.
304 S. Twyckanham
Savery, Mrs. C. E.
624 W. Colfax
Schiller, Mrs. H. A. 1813 E. Cedar
Scott, Mrs. F. M. 1628 S. Vernon
Selby, Mrs. K. E.
1327 E. Wayne, N.
Sensenich, Mrs. R. L.
128 S. Scott
Spenner, Mrs. R. W. 1917 Bader
Stiver, Mrs. D. D. 1329 Belmont
Stratigos, Mrs. J. S. 2602 S. Bend
Thompson, Mrs. J. M. 1618 Cedar
Traver, Mrs. P. C. 1010 Riverside
Vurpillat, Mrs. F. J. 2102 Cedar
Weiss, Mrs. Eugene 2517 S. Mich.
Wilson, Mrs. J. L.
1403 E. Jefferson
Wilson, Mrs. J. M.
1403 E. Jefferson
Wygant, Mrs. M .D.
1232 Lincolnway W.
Zeiger, Mrs. I. L. 3201 Mishawaka
Baker, Mrs. Walter
49 W. Moreland, Phoenix, Ariz.
Bosenbury, Mrs. C. S.
3235 Riviera Dr., Coral Gables, Fla.
Bassler, Mrs. C. R.
R. R. 4, Niles, Mich.

TIPPECANOE COUNTY

Lafayette

Bayley, Mrs. R. 1000 Pontiac
Beeler, Mrs. J. M.
Wabash Val. San.
Clauser, Mrs. A. C. 2020 Union
DuBois, Mrs. R. B. 12 S. 30th
Frey, Mrs. H. J. 927 Highland
Graham, Mrs. T. G. 1213 Wea
Hunter, Mrs. F. P. 1212 Wea
Jones, Mrs. D. M. 1406 S. 18th
Karberg, Mrs. R. J. 1600 Potomac
Klepinger, Mrs. H. E. 909 N. 21st
McAdams, Mrs. H. B. 1411 Sunset
McClelland, Mrs. D. C.
1021 Highland
Miller, Mrs. R. E. 2055 S. 9th
Morrison, Mrs. J. E. 422 S. 7th
Neumann, Mrs. K. O. 1410 S. 18th
Ratcliff, Mrs. Frank 612 S. 28th
Rothrock, Mrs. P. W. 2061 S. 9th
Sholty, Mrs. Wm. R. R. 8
Trout, Mrs. C. J. 800 State
VanReed, Mrs. Earl 806 S. 9th
Vermilya, Mrs. R. W. 1028 Tulip
Washburn, Mrs. W. W. 425 Asher

McClure, Mrs. S. E. Monon
Mitchell, Mrs. E. T. Romney
Babb, Mrs. Forrest J. Stockwell

West Lafayette

Bayley, Mrs. Wm. E. 622 Rose
Burkle, Mrs. J. C. 121 University
Engeler, Mrs. J. E.
1316 N. Lafayette
Ferguson, Mrs. W. B. 704 Bexley
Harden, Mrs. M. E. 610 Carrollton
Holladay, Mrs. L. J.
227 S. Salisbury
Hughes, Mrs. R. R. 908 Carrollton
Hunsburger, Mrs. G. W. 506 S. 7th
Loop, Mrs. F. 119 Leslie Ave.
McFadden, Mrs. J. M.
240 S. Chauncey
Peyton, Mrs. F. W.
612 Ridgewood
Spurlock, Mrs. F. H.
209 Northwestern
VanBuskirk, Mrs. E. L.
1301 Ravinia

VANDERBURGH COUNTY

Stover, Mrs. W. C. Boonville

Evansville

Acre, Mrs. R. R. 2311 Lincoln
Adler, Mrs. Ray 427 Lewis
Allenbaugh, Mrs. 3218 E. Mulberry
Anderson, Mrs. D. W.
805 E. Powell
Antes, Mrs. Earl
1201 Bonnie-View Dr.
Austin, Mrs. Eugene W.
2263 Bayard Pk. Dr.
Baker, Mrs. J. S. 2670 Stringtown
Barclay, Mrs. I. C. 1215 Parrot
Barnhart, Mrs. W. T.
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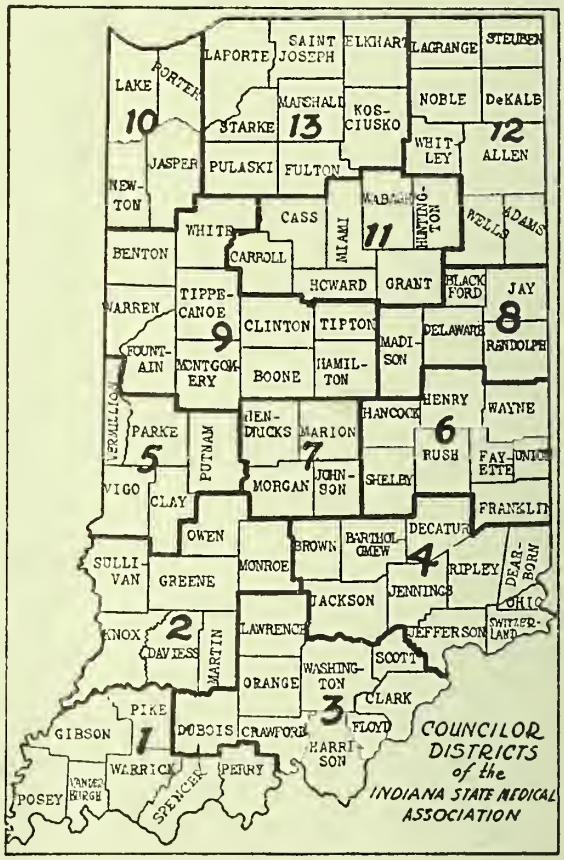
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President's Page

A PRINCIPLE AT STAKE

PHYSICIANS and hospitals are inseparable. They are obviously indispensable to each other in this modern day. America may be proud of the great number of splendid hospitals which have been developed over the past century.

In the early days the functions of a hospital were rather obvious, being confined to domiciliary care of the patients, the provision of their nursing care and their food. The physician's function, likewise, was obvious in that he was responsible for the medical or surgical treatment of the patient. But since the turn of the century there has developed an area of interest and responsibility which is common to both the hospital and the physician. This has come about because of the development of the specialties of clinical pathology, roentgenology and, still more recently, the specialty of anesthesiology. These specialties, incidentally, are plainly professional services. Moreover, they are the bedrock upon which rests modern medical care in our hospitals. It became apparent that the best interests of hospitalized patients would be served by having these specialists maintain their respective departments, with the various equipment necessary, within the hospital. The establishment of such facilities has grown up here and there under various patterns which appeared logical and convenient to the physicians and hospital administrations involved in each situation.

It developed a few years ago that some hospitals, for various reasons, concluded that it was proper and desirable to employ some physicians on a salary and resell their services to the patient for a fee. In fact, this philosophy has been approved by the American Hospital Association in their publication "Hospital." This turn of events finally came to be recognized by many physicians as having far-reaching significance. That this trend is spreading is indicated by the fact that in some hospitals not only are members of the three above-mentioned specialties involved, but surgeons and obstetricians too have been enveloped in such a plan. In brief, any doctor in any branch of medicine could logically find himself on the payroll of a hospital. In recognition of this trend the American Medical Association has officially considered this matter at its last two major conventions. The interest at each meeting was unusual as evidenced by the large number who attended the committee hearings when this matter was discussed. This "Hess Committee's" report says, in substance:

(a) It is unethical for any physician to sell his services to a hospital or any other corporation, when in turn these services are resold on a fee basis.

(b) It is unethical for any physician to share his fee secretly with any other doctor or corporation.

(c) All of these problems should and must be solved at the local level for the benefit of the public.

It must be realized that there is a profoundly important principle of medical ethics involved in this matter. Likewise, it is obvious that in most circumstances, where this principle is being violated, the serious implications involved were not recognized by those concerned. These are "growing pains" and there is nothing about the problem which cannot be solved if everyone concerned honestly appreciates the viewpoint of the other. As in every human relationship where conflicting interests are so closely associated, areas of misunderstanding are inevitable. To solve them requires only a spirit of cooperation and sincerity on the part of those involved. It is true that trouble in some local situations has resulted from ambitious or incompetent administrators or by the lack of organization on the part of hospital staff members.

In Indiana we find that approximately one-half of the hospitals have no staff organization. When problems arise who, then, will sit around the table to solve them? The rights and functions and responsibilities of hospital administrators and lay boards are recognized. In turn it must be appreciated that in this matter there is a principle at stake. Without adherence to principles our profession will cease to be a profession. We cannot compromise on this matter. To do so and allow this trend of hospitals virtually to engage in the practice of medicine will lead to a form of our socialization, potentially just as harmful to the patient's interests and our interests as socialization by the government. The doctors of the generations to come will look back and say "Thank God, those men saw the situation and had the courage to correct it," or else they will say that we allowed them to be sold into bondage.

Alfred Edison

Medical Panorama by the Associate Editor

Improvement in Streptomycin for T.B.

Dr. Paul Murphy, writing for the March 1951 *Journal of the Missouri State Medical Association*, presents a most able postgraduate review on streptomycin in the treatment of pulmonary tuberculosis. The entire article must be read to be appreciated, but the following excerpts are certainly of practical value:

Certain well established facts about streptomycin therapy must receive attention before its value in treating pulmonary tuberculosis can be discussed. The use of this antibiotic is governed and sharply limited by three factors: (1) Its action is suppressive only. (2) The period of effective use is limited by the development of resistant strains of tubercle bacilli. (3) Toxicity limits both the dosage of this drug and the duration of its administration.

* * * *

The most disappointing feature about streptomycin in the treatment of tuberculosis is the ability of tubercle bacilli to become resistant to this drug. Comparatively little is known about how this is accomplished.

* * * *

Para-aminosalicylic acid definitely delays the emergence of strains of tubercle bacilli resistant to streptomycin when these two drugs are given concurrently. Hence, unless intolerance is a contraindication, para-aminosalicylic acid is always given to the patient receiving streptomycin. The daily amount for an adult should be 12 or more grams divided into four or five doses, which are best given with food. In general, the symptoms of intolerance are the common ones encountered with large doses of any salicylic acid compound.

Recent studies carried out by the United States Veterans Administration strongly suggest that 1 gram of streptomycin injected twice a week into a patient receiving para-aminosalicylic acid daily is as good a method of administering streptomycin as any used heretofore for pulmonary tuberculosis. When dealing with either tuberculous meningitis or hematogenous tuberculosis it is still felt best to administer the streptomycin daily.

Implications of the apparent effectiveness of streptomycin therapy, when this drug is given only every few days, are that it is very far reaching. In all likelihood the emergence of resistant strains can be delayed for sufficiently long to solve at least partially this problem which has been so grievously vexing in the past and it would seem that we can broaden appreciably our indications for the use of streptomycin in pulmonary tuberculosis with relative safety from this standpoint.

A Little Comic Relief

The North Carolina Medical Journal for April 1951 carries the following editorial which might make a good clipping to keep beneath the glass on top of your desk:

HADACOL AVAILABLE ON PRESCRIPTION

At last the "new, miracle working medicine" Hadacol is available on prescription, according to letters sent out to doctors by the LeBlanc Corporation over the signature of "Leslie A. Willey, M.D., Clinical Research Director." The letter contains offers to send samples to interested physicians, and states that "HADACOL is also available under a PRESCRIPTION 'X' label."

The *Journal of the American Medical Association* for January 13 tells an interesting story about this brazen appeal to physicians. It pointed out that no Leslie A. Willey was listed in the 1950 American Medical Directory, but that the A.M.A. Bureau of Investigation had a record of a "Dr." L. A. Willey who had been arrested in Newport Beach, California, for practicing without a license and for the unauthorized use of the term "doctor." It was found that Mr. Willey was a male nurse who had been running some sort of emergency hospital until he was arrested and left town.

Hadacol, as the *Journal of the American Medical Association* shows*, is only an alcoholic solution of relatively small amounts of the vitamin B complex, plus a little iron and the now obsolete calcium glycerophosphate. An advertisement of Hadacol states that only the most expensive ingredients are used, "For instance, vitamin B-6 which costs at the factory $550 a kilogram." The editor is so unkind as to comment: "The senator (LeBlanc) forgot to say that his $550 worth of Vitamin B_6 is enough for 125,000 bottles of Hadacol (half-pints at $1.25 a bottle)."

That the manufacturer of Hadacol knows human nature is evidenced by the fact that he is a successful politician—"Senator LeBlanc of the Louisiana legislature." He is also a good advertising man, with a flair for the theatrical. He knows full well how to utilize the elementary principle of psychology laid down many years ago by the late master showman, P. T. Barnum: "The people like to be humbugged."

Should we bear such in mind when appraising the thunderings of other Senators? We wonder.

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* Hadacol—The Ethical(?) Proprietary, J.A.M.A. 145:107 (Jan. 13) 1951.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

BOOSTING MEDICAL EDUCATION

A far-reaching attack on one of America's pressing problems, inadequate medical manpower, began last week with the launching of a unique philanthropic organization, the National Fund for Medical Education.

One of the most heartening aspects of the undertaking is that it is in the best American democratic tradition. There is no government participation in the venture. Industry, the medical profession, organized labor, agriculture, a group of university presidents and 12 scientific and education foundations, among these the Lilly Endowment of Indianapolis, are behind the organization.

Present contributions provide the National Fund for Medical Education with beginning resources of more than one million dollars, with a goal of five million dollars for the first year. The American Medical Association's Medical Education Foundation, established last December, will channel its contributions from the nation's doctors into the fund.

The new undertaking is an earnest endeavor to alleviate the critical budget problems facing the nation's medical schools without resorting to the inherently dangerous expedient of federal aid. It will help to maintain and advance the standards of medicine which this nation has won in the last half-century. The National Fund for Medical Education is, therefore, of vital importance to all Americans now living and to generations yet to be born.—*Indianapolis Star.*

ANSWERS TO SOCIALIZED MEDICINE

Dr. Elmer L. Henderson, outgoing president of the American Medical Association, believes the "threat of socialized medicine is now dispelled, at least temporarily." If that is true, the AMA deserves the lion's share of the credit, both for its anti-socialization campaign and for its work in improving the standards of medical care.

Dr. Henderson is wise, however, in qualifying his optimistic view with the phrase "at least temporarily." Socializers are masters of the strategic withdrawal. They don't give up. They just retreat to fight another day.

In order to bring semi-permanent defeat to those who would force state medicine in America the voters must trounce them decisively at the polls. Meanwhile, the AMA and similar groups must strive untiringly to prove that voluntary methods can solve the nation's medical care problems.

Aid to medical education, promotion of voluntary health insurance, steps to assure an adequate supply of doctors, establishment of grievance committees, encouragement of 24-hour community medical service and efforts to solve medical care problems in rural areas are among the AMA's undertakings in meeting the challenge of the socializers.

American medicine has achieved its present high position by operating within a framework of individual freedom. There are admitted defects in voluntary medical care. But they can be, and are being, corrected without resort to statist compulsion.

The AMA has been a great public benefactor in its 104-year fight for better medical standards. And it has been a great public benefactor in its spirited fight against the socializers who would bring medicine under the stifling influence of political control. May it keep up the good work.—*Indianapolis Star.*

MR. EWING ALARMS EDUCATORS

At a meeting of the National Education Association in February it was charged that Federal Security Administrator, Oscar R. Ewing, is dominating the Office of Education.

It was stated that all press releases had to be cleared by Mr. Ewing and that even the Commissioner of Education "must clear his speeches through the Federal Security Administrator."

Commenting on these statements, an editorial in the *Hartford Courant* February 26 chided the educators for belated recognition of Mr. Ewing's dominance, and recalled that ". . . the versatile Mr. Ewing is not only in charge of social security, but the Food and Drug Administration, Public Health Service, Office of Education, and Office of Vocational Rehabilitation. As a sideline he runs St. Elizabeth's Hospital in Washington."

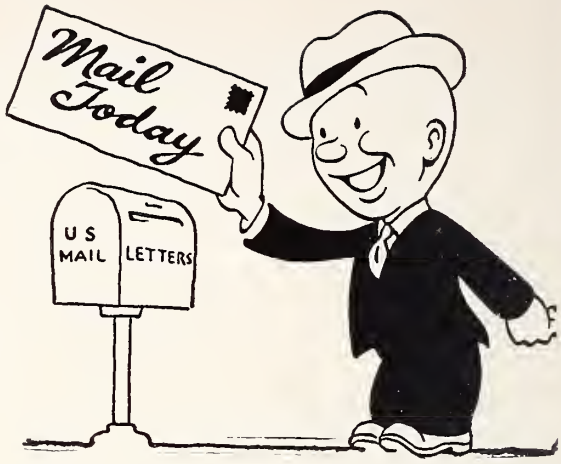
Conn. State Medical Journal

Time to Make Hotel Reservation

Going to attend the annual session of the Indiana State Medical Association in Indianapolis on Monday, Tuesday and Wednesday, October 29, 30 and 31, 1951?

It's time to make your hotel reservation.

Hotels	Rates (Start) Single	Double
Antlers, 750 N. Meridian	$4.25	$6.25
Barnes, 233 McCrea Place	$2.50	$3.50
Barton, 505 N. Delaware	$2.75	$4.00
Claypool, 14 N. Illinois	$4.60	$6.30
Harrison, 51 N. Capitol	$3.75	$5.75
Jones, 248 S. Illinois	$2.50	$4.50
Lincoln, 117 W. Washington	$4.00	$6.25
Linden, 311 N. Illinois	$2.00	$3.50
Marott, 2625 N. Meridian	$6.00	$8.00
New English, 6 W. Michigan	$2.00	$3.00
Pennsylvania, 947 N. Penn	$3.50	$5.00
Severin, 201 S. Illinois	$4.50	$6.50
Sheffield, 958 N. Pennsylvania	$3.50	$6.00
Spink Arms, 410 N. Meridian	$3.50	$6.00
Warren, 123 S. Illinois	$4.00	$6.00
Washington, 34 E. Washington	$3.50	$5.00



TIME OF EVENTS

MONDAY, OCTOBER 29

Instructional Courses, Stag Party, Golf, Trapshoot, Party for Women.

TUESDAY, OCTOBER 30

Scientific Program, entertainment at night for doctors and wives, Murat Theater.

WEDNESDAY, OCTOBER 31

Scientific Program, reception for Fifty Year Club, annual dinner and dance.

FORM FOR MAKING HOTEL RESERVATION

(Clip out this form, fill it out, and mail to hotel of your choice)

You are requested to reserve the following accommodations during the annual meeting of the Indiana State Medical Association, October 29, 30 and 31, 1951, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price.....

☐ Twin Bed Room with bath ☐ Suite

Arrival date .....A. M. .....P. M.

Departure date .....A. M. .....P. M.

Name .....

Address .....

.....

.....

A HISTORICAL VIEW OF THE MENTAL HYGIENE MOVEMENT IN INDIANA

WALTER W. ARGOW*

MILDRED FRENCH‡

INDIANAPOLIS

RECENTLY Dr. Villa Rojas, a Mexican anthropologist, observed, "Americans now have some twenty years more life expectancy than Mexicans. But what good does it do them when so many Americans spend their last years in mental institutions?" Although Doctor Rojas was begging the question, there are in this country today about eight million people who suffer from some serious personality disorder.[1] Members of the family of these persons are, of course, also affected by their situations and would swell considerably the statistics of persons concerned with problems of mental illness in a direct and personal way. Mental disease, therefore, is not the concern of the psychiatrist alone but is a problem of many professional groups and of all of our society as well.

Here in Indiana there are almost 14,000 patients in the state's mental institutions, and they occupy more than half of all available hospital beds. Not only does this represent a tremendous burden to the taxpayer, but it constitutes a staggering loss in personal productivity, earning power, domestic upheaval and human misery. Clearly mental ill health is the number one health problem of our time.

Not a New Problem

But mental disease is not a new problem; apparently it was known from the dawn of history. Superstition, fear, and misunderstanding plagued not only the mentally ill but any who tried to help persons who were popularly supposed to be "possessed." The Old Testament tells of Saul's recurring periods of depression when "the evil spirit was upon him." Nebuchadnezzar, in delirium, believed himself changed into an animal. History records many other instances of madness, which were viewed as metaphysical in origin and therefore feared. Treatment thus consisted of exorcising invading demons by such methods as were available to the representatives of the religions of the day.

The moral or humanitarian approach to the treatment of the mentally ill was slow in developing. The ancient Greeks practiced it to a degree, and it gained emphasis in France in the 1790's when Pinel released the madmen from their chains at Bicetre in Paris. But from the Middle Ages through the sixteenth and seventeenth centuries, the superstitious view of mental illness prevailed. Over 100,000 persons, many of whom were probably mentally ill, were executed as witches, and up to the late 1700's, "queer" people were hanged, imprisoned, tortured and persecuted as "agents of Satan."

When treatment passed into the hands of physicians and removal from society was required, the mentally ill were housed in jails and poorhouses. They were locked in kennel-like cells, shackled hand and foot, and left to rave until such time as death freed them. Those who were not jailed wandered about half naked and starving, the butt of taunts and teasing.

Beginning of Asylums

Toward the close of the eighteenth century, the problem of housing the insane in almshouses and workhouses became so acute in this country that a beginning was made by the erection of special institutions called "asylums." The first American institution of this kind was opened at Williamsburg, Virginia, in 1773. It remained the only state insane asylum in America for a period of fifty years. In 1821 through the initiative of Thomas Eddy, a Quaker philanthropist, the Bloomingdale Asylum was opened as a separate unit of the New York Hospital. This was probably the first hospital for the insane in this country operated primarily on therapeutic principles and the elimination of force. Other hospitals opened during this period were the Friend's Hospital in Frankford, Pennsylvania, the Maryland Hospital in Baltimore, McLean Asylum in Boston, and the Hartford Retreat in Connecticut. Most of these institutions were patterned after the Retreat founded by William Tuke in York, England, where, in the late 1700's, new and humane forms of treatment such as garden work and recreation were begun.[2]

Half a century passed. Dorothea Dix while conducting a Sunday School class through a Massachusetts jail in 1841 saw that the mental cases confined there were beaten and neglected. She launched an international crusade which resulted in the founding or enlarging of thirty-two mental hospitals, up to the time of her death in 1887. The notes concerning her investigations in Indiana were published in the *Indiana State Journal* from August to October, 1847.[3]

Then there came a change. In 1900 Clifford Beers, member of an old New Haven, Connecticut,

* Executive Director, Indiana Mental Hygiene Society.
‡ Executive Secretary, Indiana Council for Children and Youth.

family, after an unsuccessful attempt at suicide, was placed in a mental hospital. There he found such deplorable conditions and was so mistreated that he wrote on the walls of his room, "God bless our Home, which is Hell." At that time the mentally ill were housed in elaborate "gingerbread" type buildings called "hospitals," but which were still asylums in the original sense. Gradually patients were transferred from jails and almshouses to these asylums, designed for custodial care. However, many of the old practices were carried over into these new institutions in slightly modified form —chains became strait jackets and barred cages were exchanged for padded cells.

Asylums Become Hospitals

Finally dismissed from the hospital, Clifford Beers told the story of his experiences in the classic "The Mind that Found Itself." The instant popularity of this book did much to focus attention on the conditions existing in state mental hospitals. Clifford Beers spoke many times in Indiana. A book similar to his was written earlier by an Indiana woman, Anna Agnew, a patient at Central Hospital.[4] She reflected the cultural attitudes of that day toward mental illness.

The years 1910 to 1914 marked a period of popular interest in mental disorders and mental deficiency. Indiana showed itself to be fully aware of the problems in this area. In 1915, in response to a request by Amos W. Butler, then secretary to the Board of Charities, Governor Samuel M. Ralston appointed a committee to investigate what was then called "mental defectiveness" in Indiana. That term was used to cover those illnesses now included under insanity, feeblemindedness and epilepsy. Indiana was one of the first states to use the research approach in this field. The Indiana Committee, reflecting the concept of the times that defectiveness was largely tied up with poor heredity, secured the services of three eugenics field workers and began a survey of two counties in the state. Before this study was completed the committee called a conference dealing with mental defectives in relation to the home, the school and the community, and oriented to legal and medical points of view.

Creation of the Indiana Society for Mental Hygiene

It was at this conference, in 1917, that the Indiana Society for Mental Hygiene came into being. Dr. Samuel K. Smith[5] Medical Superintendent of the Eastern Indiana Hospital for the Insane (Richmond), moved that a "State Society for Mental Hygiene, to be affiliated with the National Committee for Mental Hygiene, be organized."

In the first decade of its existence the society, composed predominantly of persons professionally interested in the field, confined its efforts to informing the public on problems incident to mental disease and deficiency. Later the society developed a concern for legislation related to conditions in the state mental hospitals.

This society remained active until 1935, when it became dormant. The apparent lack of interest was only temporary, for in September of 1939, the society was revived and soon, partly through the society's efforts, nine mental hygiene clinics were established under the jurisdiction of the Department of Public Welfare. With the advent of World War II, the clinics and the society expired from lack of personnel and public interest.

Formation of the State Council for Mental Health

Records over the years indicate that little was being done by the state for the mentally ill except the provision of general custodial care. Methods of treatment other than work and ward exercise were little used. Gradually, however, the public became concerned about the hospitals and communicated their interest to their state representatives. As a result of this and the support of a leader in this field, Dr. Norman Beatty, the General Assembly created the Indiana Council for Mental Health in 1945.[6]

Doctor Beatty and another unselfish worker for the cause of mental health, Dr. LaRue D. Carter, are respectively memorialized in the naming of Indiana's two newest mental hospitals.

The Council was charged with the following seven specific duties:

1. Study the problem of mental health and disease in Indiana.
2. General supervision of treatment and care of mental patients in all public institutions.
3. Make rules and regulations establishing standards for operation and licensing of private institutions.
4. Institute programs of education for medical profession and for general public.
5. Construct and operate a psychiatric hospital for teaching, training and research.
6. Transfer psychiatric patients from one hospital to another.
7. Establish, supervise and conduct mental health clinics throughout the state for diagnosis, treatment and prevention of psychiatric disorders.

Thus, the Council was born from the belief that unless our mentally ill are offered treatment and hope, the state is committed to the burden of a social and economic cost immeasurably greater than any expenditures it might make for improvement and treatment. The Council had to decide between establishing a preventive program immediately or improving the situation of the unfortunate inmates of the mental institutions. It chose the latter, although it also lent support to the establishment of child guidance clinics with the help of federal funds. Private hospitals came forward with advanced treatment for the mentally ill at this time, and the state medical school added to its psychiatric teaching staff in order to provide more trained medical personnel in this field.

The New Mental Hygiene Society

Although progress in the treatment of the mentally ill was being made in the state, one important

task remained to be done if lasting results were to be achieved. Some interested group had to be organized to take the lead in bringing the problems of mental health to the public. Interested citizens, many of them physicians, led in a complete reorganization of the Indiana Mental Hygiene Society in 1949.[7] The purposes of the society as outlined in its constitution are:

> . . . to work for the promotion and conservation of mental health.
>
> . . . to help raise the standards of care for those suffering from, or in danger of, developing mental disorders.
>
> . . . to familiarize the public with the methods used in the care and treatment of persons who are emotionally or mentally disturbed.
>
> . . . to disseminate accurate information to aid in the carrying out of the above objectives.
>
> . . . to accelerate the attainment of the foregoing purposes by encouraging the formation of, and, thereafter, cooperating with, local mental hygiene societies throughout the state of Indiana.

The society has set itself to work with all groups interested in overcoming a basic obstacle to progress in treating mental illness . . . the attitude of the public toward the mentally ill. Such illness is still regarded as a stigma, something which should be concealed as long as possible. The result of this attitude is that frequently the mentally ill are not treated until they have reached an advanced or acute stage. The public must be made to realize that mental illnesses differ only in their manifestations from physical disease.

Another result of this attitude on the part of the public refers directly to the recovered or improved patient when he returns to society. He is denied employment; his friends behave strangely toward him; acquaintances shun his companionship. In a patient already sensitive this makes complete recovery difficult and sometimes impossible.

Along with the profession of psychiatry, the Indiana Mental Hygiene Society does not confine itself to the narrow field of mental illness, but is concerned with broader areas of human activity. The society seeks to work with other professional groups in providing instruction in parenthood for the young people, in increasing facilities for individual guidance of children to the end that we eliminate the unnecessary social waste of emotional maladjustment and its many expressions. The society's program includes work with educators in urging them to stress the development of healthy personalities and socially adaptable individuals even as they now emphasize the development of scholarship.

The effectiveness of any health education program is related to the extent to which it reaches into the minds and conscience of the people. The public can be exposed to information, but it will respond only when there is an appreciation of need. Therefore, the basic task of mental hygiene is getting information to a multitude in as digestible a form as possible. One way in which this has been approached is through the formation of local mental hygiene societies or chapters in communities throughout the state. Since its reorganization in 1949 the society has developed chapters in ten counties, and as this is being written three additional counties are applying for affiliation. Organizing committees are at work in sixteen additional counties. In all counties the cooperation and guidance of county medical societies has been sought.

The society has sponsored several projects in the past year, among them a study of the state's facilities for the care of the mentally ill, which was used as a basis for recommendations to the legislature. Seven of ten "mental health" bills introduced by legislators passed with little opposition.

Institutes for teachers, clergymen and nurses, as well as study courses for parents and the general public, were a main focus of the society's activities. Approximately 2,800 persons in thirty-nine communities have been served by the society's program in 1950. Other activities are included under the headings of community services, public information and hospital assistance.[8]

Speaking at the Annual Conference of the society in Indianapolis April 14, 1951, Dr. William C. Menninger of the Menninger Foundation said that the task which lies before us is a great one. Now as never before we must have courage, be strong in sacrifice and in action, and be united as a people.

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[1] *Statistics Pertinent to Psychiatry in the U. S.*, Report 7, Group for Advancement of Psychiatry, March, 1949.

[2] An excellent history of American mental institutions may be found in *The Mental Health Programs of the 48 States* compiled by the Council of State Government, June, 1950.

[3] Jacob P. Dunn, *Indiana and Indianians*, Chicago and New York: The American Historical Society, 1919, II, page 1091.

[4] Anna Agnew, *Under the Cloud of Personal Reminiscences of Insanity*, Cincinnati, Robert Clarke and Company, 1887.

[5] The father of Dr. E. Rogers Smith, formerly of the State Council for Mental Health.

[6] For the last two years the Council was composed of Dr. Walter Portteus, Franklin, chairman; Dr. LeRoy Burney, Indianapolis; Dr. Earl Mericle, Indianapolis; Maurice Hunt, Indianapolis; Judge John H. Morris, New Castle. The 1951 General Assembly authorized two additional members, and Edward Gallagher, Indianapolis, and Ray Smith, Indianapolis, were appointed. Arthur Loftin, for the last two years acting director, is now administrative director, and Dr. Juul Nielsen, formerly of Hastings, Nebraska, has just been named medical director.

[7] The first board of the new society was composed of Edward F. Gallahue, president; Philip B. Reed, M.D., and E. Burdette Backus, D.D., vice presidents; S. Paul Clay, Jr., treasurer; Alice H. Sanders, secretary; Murray DeArmond, M.D., Frank H. Fairchild, Marvin L. Greiber, M.D., C. Oliver Holmes, Charles C. Josey, Ph.D., and George Thorman.

[8] *Annual Report*, 1950-51, Indiana Mental Hygiene Society, 800 Underwriters Building, Indianapolis.

DEATHS OF INDIANA PHYSICIANS IN 1950

(Compiled by James B. Maple, M.D., chairman of Committee on Necrology)

(M) Member I.S.M.A.; (H) Honorary Member; (R) Retired

Name	Age	Date of Death	Address	Cause of Death
Hurst, Everett May (M)	75	Jan. 4	Cloverdale	Heart Disease.
Wood, William B. (M)	72	Jan. 5	Oakland City	Cirrhosis of the liver.
Lingeman, Edward L. (M)	62	Jan. 5	Indianapolis	Coronary artery heart disease with thrombosis.
Coleman, Walter Harvey (M)	72	Jan. 7	Evansville	Auto accident.
Bowers, Whitefield	78	Jan. 12	Michigan City	Chronic myocarditis, arteriosclerosis.
Taylor, John E. (M)	80	Jan. 13	Leopold	Pneumonia.
Van Buskirk, Edmund M. (M)	74	Jan. 18	Fort Wayne	Aplastic anemia.
Glaser, Edward M. (M)	67	Jan. 18	Brookville	Coronary heart disease, hypertension.
Mitchell, John I. (M)	69	Jan. 24	Salem	Carcinoma of the stomach and liver.
McCarty, Frank G. (M)	68	Jan. 21	Terre Haute	Coronary thrombosis, hypertension.
DeLong, Orville A. (M)	82	Jan. 29	Elizabethtown	Hiccup and broncho-pneumonia.
Bernheimer, Herman L. (M)	81	Feb. 1	Terre Haute	Stones in the common bile duct.
Thurston, Herbert F. (M)	57	Feb. 8	Indianapolis	Esophageal hemorrhage, atrophic cirrhosis.
Bailey, Walter T.	64	Feb. 10	Marion	Cerebral hemorrhage, hypertension.
Cox, Lafayette T. (M)	81	Feb. 19	Monon	Carcinoma right lung, brain and intestines.
Banning, Carrie B.	93	Feb. 25	Fort Wayne	Generalized carcinoma left breast.
Moutoux, Joseph E. (M)	75	Mar. 7	Indianapolis	Coronary occlusion.
Fisher, Pierre J. (M)	54	Mar. 10	Marion	Carcinoma of the liver and stomach.
Booher, Irvin E. (M)	69	Mar. 15	Connersville	Coronary occlusion.
Berry, David F. (M)	75	Mar. 16	Indianapolis	Coronary occlusion.
Mann, David M.	75	Mar. 21	Bloomington	Cerebral hemorrhage.
Gibson, John J. (M)	84	Mar. 24	Alexandria	Cerebral hemorrhage.
Kuhn, Benjamin F. (M)	81	April 4	Pierceton	Coronary thrombosis.
Hutchings, Byron M. (M)	70	April 5	Terre Haute	Cirrhosis of the liver.
Hartley, Clarence A., Sr. (M)	76	April 7	Evansville	Coronary thrombosis.
Phipps, David L. (M)	86	April 11	Union City	Coronary occlusion.
Noble, Thomas B., Sr. (M)	82	April 12	Indianapolis	Cerebral hemorrhage.
Glenn, Joseph M. (R)	79	April 13	Vincennes	Pulmonary edema.
Morrison, David A. (M)	54	April 19	Kokomo	Auto accident.
Washburn, Harry A. (R)	76	April 24	Waldron	Chronic valvular endocarditis, chronic bronchitis.
Knapp, George L.	78	May 7	Lafayette	Cerebral accident.
Lyle, Urban A.	72	May 31	Monticello	Cerebral hemorrhage.
Espenlaub, George H.	52	May 31	Evansville	Arteriosclerotic heart disease.
Davis, George H. (M)	75	June 1	Union City	C.V.R.D., uremia.
Davis, Dudley F. (M)	83	June 6	New Albany	Pulmonary tuberculosis.
Wiltshire, James W. (HM)	78	June 20	Bloomington	Hypertensive cardiovascular disease.
Hardy, Charles F. (M)	79	June 26	Kendallville	Carcinoma of the esophagus.
Conger, Elizabeth (HM)	78	July 5	Indianapolis	Cerebrovascular accident.
Fosler, David W. (M)	68	July 14	Indianapolis	Bacterial endocarditis.
Niblack, Earl S. (H)	80	July 14	Terre Haute	Uremia.
Preston, Wendell A. (R)	39	July 14	Angola	Suicide by firearms.
Moore, Robert M., Jr., Capt.	29	July 16	Indianapolis	Killed in action in Korea.
Mullin, Herbert Y. (M)	73	July 20	Rockfield	Hemorrhage, gastric ulcer.
Speheger, Benjamin A. (M)	41	July 24	Bedford	Coronary occlusion, bilateral pulmonary infarction.
Kelsey, Arthur J. (M)	69	July 25	Monterey	Coronary occlusion, angina pectoris.
Morrison, Clyde C. (H)	77	Aug. 8	Greensburg	Cerebral hemorrhage, arteriosclerosis.
Collins, Albert W. (H)	76	Aug. 17	Anderson	Cerebral hemorrhage, arteriosclerosis.
Smiley, James H. (M)	71	Aug. 25	Indianapolis	Arteriosclerosis.
Doan, Edgar A. (R)	78	Sept. 1	Mishawaka	Cerebral hemorrhage.
Richey, Clifford O. (M)	51	Sept. 8	Evansville	Hypertensive cardiovascular heart disease.
Ravdin, Marcus (H)	84	Sept. 12	Evansville	Coronary infarct, arteriosclerosis.
Miller, Albert W. (M)	71	Sept. 12	Indianapolis	Cerebral hemorrhage, arteriosclerotic heart disease, hypertension.
Day, Clark W. (M)	74	Sept. 23	Indianapolis	Myocardial infarction, hypertension, arteriosclerotic heart disease.
Baker, Frank M.	40	Sept. 24	Indianapolis	Myocardial infarction.
Wright, Elmer D. (M)	76	Sept. 24	Seymour	Chronic glomerulo-nephritis.
Young, Lemon R., Sr.	72	Sept. 26	Indianapolis	Cerebral hemorrhage.
Kimball, Glen D. (R)	79	Sept. 27	Marion	Splenic abscess, diabetes mellitus, general arteriosclerosis.
Ratts, John P. (R)	80	Sept. 27	Martinsville	Cerebral hemorrhage, arteriosclerosis.
Leathers, Douglas A. (M)	93	Oct. 1	Indianapolis	Arteriosclerotic heart disease.
Hull, Chester E.	67	Oct. 2	Fort Wayne	Intestinal obstruction, carcinoma of colon.
Mullikin, Hugh M. (MR)	73	Oct. 2	Terre Haute	Coronary occlusion.
Mercer, Herman A. (M)	54	Oct. 3	Jeffersonville	Heart disease.
Cabell, Abram L. (H)	84	Oct. 6	Terre Haute	Cerebral hemorrhage.

Name	Age	Date of Death	Address	Cause of Death
Wimmer, George G. (M)	75	Oct. 13	Mt. Etna	Cerebral hemorrhage, arteriosclerosis.
Evans, Evan A.	71	Oct. 16	Rosedale	Cerebral hemorrhage, hypertension.
Harrison, William H. (H)	85	Oct. 23	Kokomo	Cerebral hemorrhage, arteriosclerosis.
Klein, Hilbert P. (M)	76	Oct. 31	Fort Branch	Carcinoma of the nasopharynx.
Miller, Lawrence R. (M)	69	Nov. 3	Winslow	Cerebral hemorrhage.
Edwards, Edward T., Sr. (M)	65	Nov. 6	Vincennes	Cerebral thrombosis, generalized arteriosclerosis, diabetes mellitus.
Griffith, James B. (H)	77	Nov. 6	Crawfordsville	Coronary occlusion, auricular fibrillation, arteriosclerosis.
Shobe, Walter R. (M)	31	Nov. 8	Indianapolis	Suicide by poison, nembutal.
Meek, Loring C. (M)	79	Nov. 8	Tiosa	C.V.R.D., gangrene of the legs.
Lewis, Loren E. (M)	69	Nov. 11	Valparaiso	Coronary thrombosis, hypertension.
Seaton, Albert (M)	70	Nov. 12	Indianapolis	Carcinoma of the lungs.
Sharp, Joseph E.	77	Nov. 15	Indianapolis	Congestive heart failure, arteriosclerotic heart disease, general arteriosclerosis.
Emery, Charles H. (H)	83	Nov. 20	Bedford	Hypostatic pneumonia, chronic myocarditis, diabetes mellitus.
Johnson, Ernest N. (M)	70	Nov. 23	Sandborn	Coronary thrombosis.
Anderson, Ralph J. (M)	65	Dec. 5	Indianapolis	Cerebral hemorrhage, generalized arteriosclerosis.
Wales, Ernest D. (H)	77	Dec. 11	Indianapolis	Coronary occlusion.
Tennant, Lewis W. (RH)	79	Dec. 17	Fort Wayne	Coronary thrombosis, coronary atherosclerosis, paralysis agitans.
McKittrick, William O. (M)	71	Dec. 19	Washington	Carcinoma of the biliary tract.
McConnell, Maude W. (R)	84	Dec. 19	Sullivan	Cerebral hemorrhage, cardiovascular disease.
Clutter, Thomas J. (M)	73	Dec. 23	Mentone	Carcinoma of the prostate, multiple abscesses.
Lynch, Otho R. (M)	70	Dec. 25	Lafayette	Atelectasis, broncho-pneumonia.
Higgins, Otis C. (M)	74	Dec. 26	Lebanon	Coronary occlusion, arteriosclerosis, diabetes mellitus.
Dutton, Hayes H. (M)	74	Dec. 28	Martinsville	Hypostatic pneumonia, cerebral arteriosclerosis.

COMPULSORY HEALTH INSURANCE OR SOCIALIZED MEDICINE

Alice Marie Emhardt*

INDIANAPOLIS

PRESIDENT TRUMAN and his Federal Security Administrator, Oscar Ewing, have promoted a program of Socialized Medicine and increased taxation under a disguised name, Compulsory Health Insurance. If the American people accept this program, they will be advancing the American democracy one more step toward a socialized state.

Under this insurance bill is contemplated a payroll tax of 1.5 percent on all earnings up to the first $4,800. This tax deduction would be matched by a like contribution from employers to finance hospital and medical care. In addition, the bill calls for another .5 percent of salary from each source to finance dental and nursing care. A National Health Insurance Board would be set up to run the program. Agreements would have to be made between the medical profession and the state agencies before the doctor and hospitals would receive payments for treating the sick.

The element of humanitarianism behind this bill certainly is commendable, but overpowering this is the element of politics. Through propagandizing, the administration has formulated a popular issue to support for the purpose of gathering votes in the future. Then there is the element of power. If this plan should go through, Mr. Ewing and his successors will hold prime power over one of the most vital aspects of American life. No better situation could exist for the originating and establishing of a bureaucratic empire. Having watched the growth of other bureaucratic empires, we know some of the unfavorable aspects, including costs and inefficiency, that this type of government offers.

One of the arguments for the bill is that the number of people covered by voluntary insurance is small; and as prices rise in inflation, the individual cannot provide for his medical needs. This point is most misleading. Statistics presented by the Bureau of Labor Statistics show that the Con-

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sumer's Price Index of 1949 was 169.1 in comparison with the total medical care program average at an index of 144.9 (Index normality, base 100, set on the 1935-1939 standards). Only hospitalization had increased in proportion to the Cost of Living, and this phase of medical care is covered by voluntary insurance. The hospitalization increase has occurred because hospitals are dependent upon goods and service—labor, fuel, and food —quantities which have undergone inflation. The statistics of voluntary insurance programs, including Blue Cross, Blue Shield, and private insurance carriers, show that at least sixty million people have some coverage; and the rate of expansion is tremendous (8,000,000 per year).

If the American people do not have adequate means to pay for medical care, the fault, in most instances, lies in the fact that their purchase of medical care is largely a matter of what they *choose* to afford rather than what they *can* afford. In a free society the consumers are the dictators, and they make their own decisions. Statistics show that the consumer has decided he can afford one and one-half times as much for alcoholic beverages, and another one and one-half times as much for recreation as for medical care. He has decided he can afford twice as much for tobacco as for physicians' services. These are not the decisions of the medical profession or a group in Washington; they are the decisions of 144 million people. As long as people choose these things, the advocates of Compulsory Health Insurance will be hard pressed to prove that over half of our population cannot afford medical care. This fact they have stated to be true. Compulsory Health Insurance would require the people to spend more, and they should spend more for medical care; but the method of compulsory spending through government planning takes from the hands of the people the right to decide how they shall use their money. Is this the principle upon which a democracy with free enterprise and free competition was established? Why do we not educate the minds of the people so that their decisions in spending would be done wisely?

Mr. Ewing has stated that Compulsory Health Insurance cannot be called Socialized Medicine. The government would merely collect money and see that it is properly dispensed. There would be no governmental interference with the patient's free choice of doctor, no dictation to the medical profession as to where and how to practice medicine, no heavy hand of bureaucracy on the initiative which stimulates research. The relationship between doctor and patient, often delicate and sometimes vital, would be preserved. Government agencies and officials would simply control the purse. In opposition to this statement, the American Medical Association points out that theoretically Compulsory Health Insurance is not Socialized Medicine. However, bureaucratic forces, once intrenched, never would voluntarily recede. As surely as day follows night, dependence of the medical profession on the funds collected and disbursed by the state would, in a short time, lead to full subjugation. New directives would soon flow from Washington, which would make it necessary for every doctor, in the interest of his own economic self-preservation, to restrict his activities to a definite panel of patients, and for patients in turn to consult only one particular doctor. Freedom of choice would soon be lost, and medicine on the assembly line would be with us.

If medical care falls under a taxation program, as have old age, accident possibilities and savings, then why not accept taxation for distribution of food, clothing and wages? Through these steps a free nation is turned into a socialized state in which the individual is nothing but a piece of machinery. If the American people accept this program, which is predicted undoubtedly to develop into Socialized Medicine, a government supported by power and greed will step in to regiment the lives of American citizens.

The following resolution was passed unanimously by the delegates to the annual Spring Convention of the American Council of Christian Churches, meeting in Nashville, Tennessee, April 25-29, 1951.

SOCIALIZED MEDICINE

The American Council of Christian Churches reaffirms its resolution of April, 1949, against socialized medicine. Freedom of the individual, freedom of the doctor, and freedom of medical research are essential to the preservation of a free society.

We are aware of the fact that among the clergy and in certain church groups there is increasing pressure for government socialism beginning with socialized medicine. The leadership of Methodist Pink Bishop G. Bromley Oxnam on the committee for the nation's health spearheading this drive is only a part of the over-all program to socialize the entire world under the guise of establishing the Kingdom of God.

The tyranny, abuse, corruption, confusion, demoralization, and irresponsibility attendant upon any effort to make the state responsible for a person's health will be a valid judgment of the Almighty God upon those who lightly esteem their God-given freedom. No state can assume either the responsibility which belongs to an individual or the prerogatives which belong to God Almighty.

Christian people must expose and resist the campaign now being waged for socialized medicine. These appeals actually are based upon the lowest motives, including the offer of something for nothing in order to win votes.

News Notes

DOCTOR DALTON HONORED

Dr. John Eric Dalton, of Indianapolis, was elected to membership in the American Dermatological Association in May. This is only the fourth occasion when an Indiana physician has been elected to membership in this society, which is comprised of a limited group of dermatosyphilologists in the United States and Canada. The other three Hoosier members were the late Dr. Alembert Winthrop Brayton and the late Dr. Frank Cregor, both of Indianapolis, and Dr. Werner Duemling, formerly of Fort Wayne, now living in California, who was elected to membership while a resident of Indiana. Doctor Dalton has been active in the formation of the Alembert Winthrop Brayton Skin and Cancer Foundation, and is head of the Department of Dermatosyphilology of Indianapolis General Hospital.

Dr. Norman R. Booher, of Indianapolis, has been appointed to the Marion County Board of Public Welfare.

Dr. Basil B. Dulin has sold his practice in Portland, and has moved to Indianapolis, to take postgraduate work in radiology. His practice has been purchased by **Dr. Ralph M. Steffy**, who recently completed three years of postgraduate work in medicine.

Dr. Harold Griffith, of Vevay, has given up his practice there to take special training in radiology at Indiana University Medical Center.

Dr. Karl R. Ruddell, of Indianapolis, has been appointed a member of the Indianapolis Board of Public Health.

Dr. Paul E. Strueh, ear, nose and throat specialist from Chicago, has become associated in practice with **Drs. William H. Field, Charles F. Leich** and **Thomas W. Wesson**, at 124 South First Street, Evansville.

Dr. Philip B. Lockhart, a 1944 graduate of the Columbia University School of Medicine, has begun the practice of medicine in South Bend. For the past three years he has been in radiology residency at the Indiana University Medical Center.

After completing his residency at Indiana University Medical Center recently, **Dr. Dempsey C. Strange** is now at Eckford Memorial Hospital at Starkville, Mississippi.

Dr. Richard M. Davis is now associated in practice with his father and brother, **Drs. Merrill S. Davis** and **Joseph B. Davis**, at 514 Marion National Bank Building, in Marion. He is a 1944 graduate of Indiana University School of Medicine, and following active duty with the U. S. Army Medical Corps, from 1946 to 1948, he returned to the Mayo Clinic to complete a fellowship in surgery, begun before his military service. He will specialize in surgery and orthopedics.

Dr. Henry H. Alderfer has also become associated with the Doctors Davis in Marion. His specialty is internal medicine, cardiac and pulmonary diseases. Doctor Alderfer is a 1943 graduate of Jefferson Medical College, Philadelphia. Following his internship he entered the U. S. Army Medical Corps, where he served as chief of service at a base hospital in France, from 1943 to 1944. After his release from service, he returned to residency in Jefferson Hospital in Philadelphia, and then served as assistant professor of preventive medicine at the University of Wisconsin.

Dr. Mary Alice Norris, formerly of Indianapolis, who is now Mrs. Joe Free Surratt, will take up residence in Rio in August, where her husband will be stationed as artillery advisor to the Joint Brazil-U. S. Military Commission. Doctor Norris plans again to enter practice there.

Dr. Robert C. Peacock has opened an office for the practice of Urology in Muncie. A 1942 graduate of Indiana University School of Medicine, he has served for three years as a flight surgeon in the air corps.

Dr. Philip B. Reed, of Indianapolis, was recently named chairman of the executive committee of the Indiana Mental Hygiene Society.

Dr. Houghton W. Baxley, present manager of the Veterans Administration hospital in Fort Benjamin Harrison, Indiana, has been appointed manager of the Huntington, West Virginia, V-A hospital, effective June 30. He will replace Mr. Samuel R. Goodwin, Huntington hospital manager, who will retire at the end of June.

Replacing Doctor Baxley at Fort Benjamin Harrison will be Dr. Clifton H. Smith, who will move up from the V-A hospital in Atlanta, Georgia.

Mr. P. O. Ferrel, of Indianapolis, was elected to the Board of Directors of the American Heart Association, for a three year term, at the association's annual meeting in Atlantic City in June.

Dr. John M. Byrne, of Lawrenceburg, Tennessee, has taken over the office of the late Dr. Hubert Gros in Delphi, where he will practice medicine and surgery. He is a 1941 graduate of New York University School of Medicine, and served his internship at Bellevue Hospital in New York, following which he entered the service for three and one-half years. Following his discharge from the service, he took postgraduate work in surgery at the New York University, and served residencies at Wilson Hospital, Johnson City, New York, and at St. Elizabeth Hospital in Lafayette. He has been in practice in Lexington, Kentucky and at Lawrenceburg, Tennessee.

EXAMINATION FOR MEDICAL OFFICERS

A competitive examination for appointment of Medical Officers in the Regular Corps of the United States Public Health Service will be held on September 4, 5, and 6, 1951. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received no later than August 6, 1951.

Application forms and information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C., attention: Division of Commissioned Officers.

The nation's death rate from tuberculosis dropped about 9 percent in 1949, to 26.2 per 100.000 population, **Dr. W. Palmer Dearing**, Acting Surgeon General of the Public Health Service, Federal Security Agency, announced. During the first 11 months of 1950, a further decline of 15 percent occurred, and the rate for this period was 22.6 per 100,000 population, he said, explaining that these figures are provisional, as data for 1949 and 1950 were based on a 10 pereent sample of death certificates obtained from each state and the District of Columbia.

RESEARCH FELLOWSHIPS

The Arthritis and Rheumatism Foundation is offering research fellowships in the basic sciences related to arthritis. Fellowships will be granted at both the predoctoral and postdoctoral levels. The predoctoral fellowships will range between $1,500 and $3,000 per annum, and the postdoctoral from $3,000 to $6,000. The deadline for these applications is November 15, 1951. Application forms may be obtained by writing the Medical Director, Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, N. Y.

RESEARCH GRANTS

Among thirteen new unclassified research contracts, recently announced by the U. S. Atomic Energy Commission, was one for Indiana. A contract was granted to Dr. H. C. Brown at Purdue University for research in chemistry of the polyvalent metal halides.

The Fifth Congress of the Pan-Pacific Surgical Association will be held in Honolulu November 7 to 19, 1951. The scientific program will begin on November 12 and continue through November 16. Reservations should be made through the Pan-Paeific Surgical Association, Young Hotel Building, Honolulu, Hawaii.

COURSE IN POSTGRADUATE GASTROENTEROLOGY

The National Gastroenterological Association course in Postgraduate Gastroenterology will be given at the Drake in Chicago, Illinois, on September 20, 21, 22, 1951.

The course will again be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, and Dr. I. Snapper, Director of Medical Education of The Mt. Sinai Hospital, New York, N.Y.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, New York.

The Sixth Annual Postgraduate Course in Diseases of the Chest, sponsored by the Council on Postgraduate Medical Education and the Illinois State Chapter of the American College of Chest Physicians, will be presented at the St. Clair Hotel, Chicago, Illinois, September 24 through 28, 1951.

This course will emphasize the recent advancements in the diagnosis and treatment of chest diseases. The course is open to all physicians, but the number of registrants will be limited. Tuition fee is $50.00; applications will be accepted in the order in which they are received. Applieations should be sent to the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

The American College of Surgeons will hold its 37th annual Clinical Congress in San Francisco, November 5 to 9, 1951, with headquarters at the Fairmont Hotel and Civic Auditorium. The thirtieth annual Hospital Standardization Conference is scheduled to be held concurrently, with meetings in the Civic Auditorium, as a part of the Congress. The combined programs will include scientifie and technical exhibits, color television, cine clinics, medical motion pictures, scientific sessions, panel discussions, conferences, symposia, official meetings, and forums.



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A.M.A. WASHINGTON OFFICE NEWS

Dr. Lovelace Heads Medical Policy Council, Succeeding Dr. Meiling. Defense Secretary Marshall has announced appointment of Dr. W. Randolph Lovelace II, as chairman of the Armed Forces Medical Policy Council, effective July 1. He succeeds Dr. Richard L. Meiling, who returns to teaching at Ohio State University College of Medicine.

Dr. Lovelace has been a member of the Council since its formation early in January. The function of the Council is "to develop and establish uniform or joint programs for Army, Navy and Air Force, including joint utilization and cross-servicing of facilities; review medical phases of budget estimates and legal proposals; initiate programs for standardization of various technical activities of the services; represent the Secretary in dealing with other governmental and non-governmental agencies; develop close cooperation and mutual understanding between civilian and military medicine and the allied professions."

The Council, with Dr. Howard Rusk's Health Resources Advisory Committee (now reporting to Office of Defense Mobilization), also advises the secretary on the total number of medical reservists to be called to duty at any one time. The Council is made up of the three military surgeons general; Dr. I. S. Ravdin of Philadelphia, professor of surgery at University of Pennsylvania; and Dr. James P. Hollers of San Antonio, Texas, a practicing dentist and former officer of American Dental Association; and Dr. Albert R. Shands, Jr., of Wilmington, Delaware. He will occupy the position formerly held by Dr. W. Randolph Lovelace II. Dr. Shands, an authority on orthopedic surgery, is medical director of the Nemours Foundation and surgeon-in-chief of the Alfred I. duPont Institute of Wilmington.

Dr. Lovelace's residence is Albuquerque, N. M., where he is head of the Section on Surgery and a member of the Board of Governors of Lovelace Clinic, as well as a trustee of the Lovelace Foundation for Medical and Educational Research. He will live in Washington while chairman of the Council.

Another Defense Department appointment is that of Dr. Lowell T. Coggeshall of the University of Chicago as chairman of the Committee on Medical Sciences of the Research and Development Board. He replaces Dr. Francis G. Blake of Yale University, who had headed the committee since its formation in 1948. Dr. Coggeshall, a former deputy chairman of the committee, is dean of the Division of Biological Sciences and chairman of the Department of Medicine at University of Chicago.

FSA Proposes U. S. Pay for Hospitalization of Aged. A program for U. S.-financed hospitalization of the aged, on which sponsors have been working quietly for many months, has been made public in part. Sponsors include a group of Federal Security Agency officials and some labor leaders, an indication that the plan might be designed for use in the 1952 Presidential campaign.

Officially, neither the White House nor FSA Administrator Oscar Ewing's office would comment on the idea in any way. However, it is known that it was Mr. Ewing himself who first gave the facts to news men. Because of refusal by the White House and Mr. Ewing's office to answer any questions, it has not been possible to confirm a report that President Truman plans to make hospitalization for the aged the subject of a special message to Congress.

The plan calls for the federal government to pay hospital costs for persons 65 years of age or older who are covered by social security. They would be eligible for hospitalization even if earning sufficient money to make them ineligible for old age insurance payments. Sponsors of the plan have not made public their estimate of cost, but have indicated that a possible 7,000,000 persons would be covered.

Civil Defense Awaits Biomedical Data On Eniwetok Bomb Tests. Mice, pig and dog survivors of recent atomic weapon tests on Eniwetok atoll in the Pacific are expected to serve as basis for important biomedical research of value in civil defense planning. Civil Defense Administrator Millard Caldwell, following Atomic Energy Commission disclosure of tests, said Eniwetok experiments on shelters demonstrated that CDA is on the right track. In this connection CDA has just completed two-day conference of state civil defense engineers and technicians on subject of shelters in critical target areas. Brig. Gen. James Cooney, radiation safety adviser to the Eniwetok task force, reported later that surveys in immediate area of overhead bomb bursts failed to reveal any contamination of a serious nature. Food and drinking water outside the destroyed area continued to be fit for consumption. Dr. Cooney also reported tests showed rescue and recovery work could begin within two minutes after a high aerial burst.

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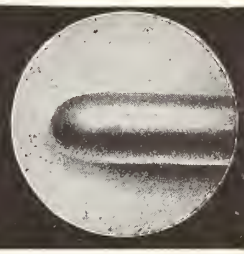
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Deaths

Everett E. Padgett, M.D., of Indianapolis, president of the Indiana State Medical Association in 1934, died on May 24, at the age of seventy-two, after a brief illness. He was a 1905 graduate of Rush Medical College, in Chicago, and had practiced surgery in Indianapolis for forty-five years.



Doctor Padgett was Councilor from the Seventh District from 1927 to 1931, serving as chairman of the Council in 1930 and 1931. He was a member of the Executive Committee in 1930, 1931, 1933 and 1934, and had served on many association committees. He was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Morton Helper, M.D., of Evansville, died on May 10 after a long illness. He was thirty-nine years of age. A graduate of the University of Michigan Medical School, Ann Arbor, in 1936, Doctor Helper went to Evansville in 1941, following postgraduate work in radiology. From 1942 to 1946 he served in the Army Medical Corps. He was treasurer of the Vanderburgh County Medical Society and a member of the Indiana State Medical Association, as well as a Fellow of the American Medical Association.

John M. Lochhead, M.D., retired physician of Indianapolis, died on May 15, following a long illness. He was eighty-three years of age. He was a graduate of the Homeopathic Medical College of Missouri, in St. Louis, in 1894, and had been a resident of Indianapolis for fifty years.

Roy D. Morrow, M.D., of Connersville, died suddenly on May 30, at the age of sixty-seven. A 1907 graduate of the Indiana Medical College School of Medicine of Purdue University, in Indianapolis, Doctor Morrow began the practice of medicine in Richmond. In 1919 he went to Connersville, where he had practiced ever since. He was a member of the Fayette-Franklin County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Fred Bierly, M.D., of Elizabeth, died on May 11. He was sixty-nine years of age. A graduate of the Kentucky School of Medicine in 1908, he had practiced at Elizabeth for forty-two years. Doctor Bierly was a member of the Harrison County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Kathryn M. Whitten, M.D., former Fort Wayne physician, was killed in an automobile accident in Los Angeles, where she had been residing since her retirement five years ago. She was sixty-nine years of age, and was a graduate of the Chicago College of Medicine and Surgery in 1917. She had practiced in Fort Wayne for twenty-five years before her retirement.

Louis C. Hicks, M.D., retired Indianapolis physician, died on May 28, at the age of seventy-two. He graduated from the Medical College of Indiana, in Indianapolis, in 1903, and had lived in Indianapolis for the past thirty-six years.

Hamilton M. Southworth, M.D., of Owensburg, died on May 26, at the age of seventy. He was a graduate of the Albany Medical College, Albany, New York, in 1905, and had practiced in New York state and Montezuma before opening his practice in Owensburg.

The Third Annual Rural Health Conference will be held in the South Ballroom of the Union Building at Purdue University, Lafayette, at 9:30 a.m. (CDST) on Tuesday, July 31, 1951. It is sponsored by the Committee on Rural Health of the Indiana State Medical Association, in cooperation with the Agricultural Extension Service of Purdue University. There is no registration fee, and the conference is open to the public.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

COUNCILOR DISTRICT MEETINGS

SECOND DISTRICT

Dr. Arthur G. Blazey of Washington was elected councilor of the Second district at the annual meeting held at Washington on May 24. He will succeed Dr. William C. Reed of Bloomington next January 1.

Dr. J. S. Brown of Carlisle was re-elected secretary. As the next meeting will be held in Linton, probably in June, 1952, the Greene County Medical Society was authorized to name one of its members as district president.

Dr. C. Basil Fausset of Indianapolis gave a paper on "Psychosomatic Surgery." Discussants were Drs. Reed and M. M. McDowell of Vincennes. Dr. H. D. Junkin of Paris, Illinois, discussed "Skeleton Pinning and External Fixation of Fractures," with Dr. Irwin H. Scott of Sullivan as the discussant.

Speakers at the dinner were Dr. Alfred Ellison of South Bend, president of the Indiana State Medical Association, and Dr. Lester D. Bibler of Indianapolis, chairman of the Section on General Practice of the state association.

Dr. C. Phillip Fox of Washington, district president, presided.

Members of the Woman's Auxiliary met at the home of Dr. and Mrs. Arthur A. Rang, with Mrs. Blazey, councilor of the district, presiding. Mrs. Myron L. Curtner of Vincennes was elected to succeed Mrs. Blazey. Mrs. William J. Stangle of Bloomington, second vice-president of the state Woman's Auxiliary, spoke. The women joined their husbands at dinner.

THIRD DISTRICT

Dr. Joseph C. Dusard of Bedford was elected president of the Third District Medical Society at a meeting held at Silvercrest hospital, New Albany, on May 23. He was authorized to appoint the secretary. The 1952 meeting will be held at Spring Mill State Park, near Mitchell.

Dr. Alfred Ellison of South Bend, president of the Indiana State Medical Association, spoke on activities of the association. Scientific speakers were Drs. E. L. Pirkey, Maurice M. Best, Jr., and James C. Drye, all of Louisville.

Members of the Woman's Auxiliary met at the New Albany Country club. Mrs. H. T. Goodman of Terre Haute, president-elect of the state auxiliary, was present. Mrs. Nelson A. Wolfe of New Albany, district president, presided.

EIGHTH COUNCILOR DISTRICT

Dr. Forrest E. Keeling, of Portland, was elected Councilor for the eighth district during the annual meeting held in the Country Club of Portland on May 23, 1951. Approximately sixty-five members of the district registered for the meeting. Dr. Keeling served as a Colonel in World War II, and had the distinction of taking the first hospital group into the Philippines, when the allies returned there.

Golfers began vieing for the prizes in their annual tournament at 1:30, with the business session taking up at 5:30. Officers for the district to serve for the coming year are as follows: President, Dr. G. B. Wilder, Anderson; Secretary-Treasurer, Dr. Warren Fisher, Anderson. A motion for changing the district by-laws to limit the term of the Councilor to two consecutive terms was presented and will be acted upon at the 1952 meeting.

Following a smorgasbord dinner, J. William Wright, M.D., Indianapolis, president-elect of the Indiana State Medical Association, expressed the official greeting of the association to the district. He also explained many of the activities of the Association, and invited increased use of the headquarters office by the membership.

The principal speaker of the evening was Donald B. Effler, M.D., of the Department of Chest Surgery, Cleveland Clinic, Cleveland, Ohio, who gave a paper on "Bronchogenic Carcinoma."

The Auxiliary district meeting and dinner was held in the Portland Presbyterian Church. Mrs. F. M. Fargher, Michigan City, President of the Woman's Auxiliary to the Indiana State Medical Association, was a guest at the meeting.

NINTH COUNCILOR DISTRICT

Members of the Ninth Councilor District held their meeting on May 24, 1951, at the Lafayette Country Club, with an attendance of 149. The 1952 meeting will be held on May 24, 1952, in Crawfordsville.

A full day of activity was planned for those in attendance. Registration got under way at eight in the morning, with the golfers teeing off at 8:30 a.m. for their annual tournament. Luncheon was served at noon and the afternoon was devoted to the scientific program.

Papers delivered during the scientific session were all by Lafayette physicians who had been in practice less than ten years. Dr. Martin L. Harshman gave a paper on "Headache." Dr. Roland E. Miller talked on "Dermatitis in Pedi-

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atrics." Dr. Robert W. Vermilya discussed "Stellate Ganglion Block." "Painful Feet" was discussed by Dr. William B. Ferguson and "Breast Feeding" was the topic of Dr. Ramon B. DuBois.

Delegates of the district met following the scientific program to discuss association affairs and the forthcoming meeting of the House of Delegates.

During the afternoon the Auxiliary met in the Purdue Union building for a social program. New officers elected by the Auxiliary for the coming year are as follows: President, Mrs. N. F. Peacock, Crawfordsville; Vice-President, Mrs. Boyd Burkhardt, Tipton; Mrs. Richard E. Hughes, Lafayette, Secretary. Mrs. F. M. Fargher, Michigan City, President of the Woman's Auxiliary to the Indiana State Medical Association, was a guest at the meeting.

Dr. J. William Wright, Indianapolis, President-elect of the Indiana State Medical Association, talked briefly on association affairs, and conveyed the official greetings of the association to the district.

The principal address of the evening was given by George D. Scarseth, Ph.D., Lafayette, who is the Director of Research, American Farm Research Association and Research Consultant, Standard Fruit and Steamship Company. His subject was "Soils, Civilization and Our Health." Dr. Scarseth's talk was based on his world-wide travels and dealing with soils, people and their environments. His interweaving of wit and unusual humor brought great praise from his audience.

Officers for the district are Roland E. Miller, M.D., Lafayette, President; Hugh B. McAdams, M.D., Lafayette, Secretary; and Wemple Dodds, M.D., Crawfordsville, Councilor.

ELEVENTH COUNCILOR DISTRICT

Fifty-three members of the eleventh councilor district met at the Mississinewa Country Club at Peru on Wednesday, May 16, 1951 for their eighty-seventh semi-annual meeting. Officers elected for the coming year were as follows: O. G. Brubaker, M.D., North Manchester, President; C. R. Herd, M.D., Peru, Secretary; Elton R. Clarke, M.D.; Kokomo, Councilor; and E. B. Jewell, M.D., Logansport, Necrologist. The fall meeting of the district will be held in Wabash on September 19, 1951.

The afternoon scientific program drew many comments of praise as R. Gordon Brown, M.D., of Chicago, Illinois, gave an illustrated lecture on "The Medical Aspects of Atomic Energy." Doctor Brown had spent much time in the Atomic areas and had many graphic illustrations of the effects of atomic bombing upon the populace of Japan. Many scientific instruments were displayed for inspection by those in attendance.

The Woman's Auxiliary met during the afternoon in the Presbyterian Church of Peru, and were entertained by a book review by Mrs. D. R. Garber, who reviewed the first act of "Peter Pan." A style show closed the program.

Wives of the members of the eleventh district joined their husbands for the evening program. Dr. Alfred Ellison, South Bend, president of the Indiana State Medical Association, reviewed the work of many of the committees of the association and explained how the organization worked in the interest of the medical profession.

Mr. Walter Bixler, Peru attorney, gave the principal address.

TWELFTH COUNCILOR DISTRICT

Thirty-five members of the Twelfth Councilor District met in the Chamber of Commerce Building, Fort Wayne, on Thursday, May 17, 1951, for their annual spring meeting.

Beginning the scientific sessions at 2:45 p.m., Dwight E. Clark, M.D., Department of Surgery, University of Chicago, gave a paper on "An Evaluation of the Use of Radio-Active Iodine."

Dr. Leon Jacobsen, of the Department of Hematology, University of Chicago, discussed "Radio-Isotopes in the Treatment of Neoplastic and Allied Disorders of the Bloodforming Tissues."

During the business session, the following officers were elected: Wm. J. Gerding, M.D., Fort Wayne, President; Edward H. Schlegel, M.D., Fort Wayne, Vice-President; James M. Burke, M.D., Decatur, Secretary. Councilor for the district is Dr. M. B. Catlett, Fort Wayne, and Dr. M. L. Habegger, of Berne, is Alternate Councilor.

Dr. W. U. Kennedy, of New Castle, President of Blue Shield, spoke on the advancement and growth of the Indiana Blue Shield Plan.

The Woman's Auxiliary met during the afternoon in the Wolf and Dessauer Department Store of Fort Wayne where they were entertained with a style show and tea.

The meeting closed with a banquet served in the Chamber of Commerce dining room for the members and their wives. Dr. Alfred Ellison, South Bend, President of the Indiana State Medical Association, spoke briefly on the activities of the Association. Richard F. Mills, of Indianapolis, delivered the principal address of the evening, a humorous lecture on "Coffee."

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LOCAL SOCIETY REPORTS

Fayette-Franklin County Medical Society members met at the Connersville Country Club on May 9, when a Red Cross blood bank program for civil defense was organized. Dr. Thomas Radley, professor of orthopedics at the University of Cincinnati, spoke on "Treatment of Fractures." Fourteen members were present.

Greene County Medical Society members held a meeting in Linton on May 17. Eighteen members and guests were present to hear Dr. Nathaniel Ewing of Vincennes speak on "Cancer of the Breast."

Huntington County Medical Society members held a meeting at the Hotel LaFontaine in Huntington on April 3, when they participated in the Telephone Postgraduate program. Sixteen members were present.

Another meeting was held on May 1, at which members of the Woman's Auxiliary were guests. Thirty-two members and guests attended this meeting.

Jasper-Newton County Medical Society met at the Brook Hotel, in Brook, on May 9. Dr. E. S. Jones, of Hammond, addressed the members on "Advances in Surgery in the Last Twenty-Five Years." Members of the Woman's Auxiliary were also present at this meeting.

Madison County Medical Society members met in Elwood on May 28, when Dr. Walter Alvarez, of Chicago, was the guest speaker. His subject was "What Makes People Nervous?" Ninety members and guests were present.

Montgomery County Medical Society members met at Culver Hospital in Crawfordsville on May 17. Twenty-two members were present to view a motion picture on "Survival Under Atomic Warfare."

Putnam County Medical Society members held a meeting in Greenfield on April 13. Dr. E. W. Mericle, of Indianapolis, spoke on "New Methods in Psychiatry," and Dr. C. Basil Fausset, of Indianapolis, spoke on "Neurosurgery." Fifteen members were present.

Ripley County Medical Society members met at the Milan Country Club, in Milan, on May 8. Seven members were present for the discussion of the Rural Health Conference Meeting and of Civil Defense plans.

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MONTHLY REPORT—APRIL, 1951

Disease	Apr. 1951	Mar. 1951	Feb. 1951	Apr. 1950	Apr. 1949
Brucellosis	1	1	1	1	1
Chickenpox	224	357	358	346	613
Conjunctivitis	8	0	0	12	13
Diphtheria	9	12	2	22	29
Encephalitis	1	3	2	3	2
Erysipelas	2	3	1	0	0
Influenza	20	74	64	37	9
Infectious hepatitis	11	38	11	5	1
Measles	705	1235	624	1734	1146
Meningitis					
Unclassified	7	8	5	4	8
Influenzal	2	0	2	1	1
Meningococcal	4	3	3	10	2
Mumps	225	339	182	132	339
Pneumonia	52	64	42	122	55
Poliomyelitis	2	4	4	2	2
Rabies in animals	49	37	49	70	95
Rubella	287	71	12	58	419
Scarlet fever	207	313	233	268	309
Tinea capitis	4	2	5	0	13
Tuberculosis					
Pulmonary	164	221	135	288	216
Other forms	22	15	9	14	10
Vincent's angina	1	0	0	2	0
Whooping cough	51	43	97	188	82

MONTHLY REPORT—MAY, 1951

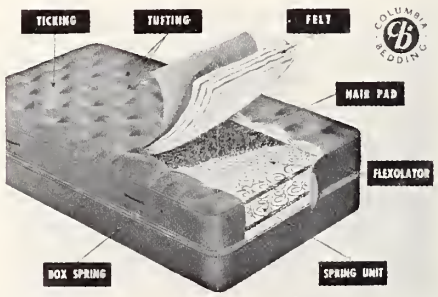
Disease	May 1951	Apr. 1951	Mar. 1951	May 1950	May 1949
Chickenpox	156	224	357	278	195
Conjunctivitis	9	8	0	7	7
Diphtheria	6	9	12	13	16
Dysentery, bacillary	1	0	0	0	0
Encephalitis	3	1	3	1	5
Erysipelas	1	2	3	1	4
Food poisoning	3	0	0	3	1
Impetigo	5	0	2	3	3
Influenza	38	20	74	6	0
Infectious hepatitis	9	11	38	1	0
Measles	645	705	1235	2244	596
Meningitis,					
Unclassified	6	7	8	2	4
Meningococcal	2	4	3	4	2
Mumps	292	225	339	125	173
Pneumonia	44	52	64	20	16
Poliomyelitis	2	2	4	3	2
Rabies in animals	58	49	37	52	94
Rheumatic fever	5	0	1	0	4
Rocky Mt spotted fever	1	0	0	0	2
Rubella	216	287	71	83	425
Scarlet fever	102	207	313	170	132
Septic sore throat	5	0	8	0	8
Tetanus	1	0	0	2	1
Tuberculosis,					
Pulmonary	178	164	221	206	208
Other forms	7	22	15	30	11
Typhoid fever	2	0	4	1	2
Vincent's angina	1	1	0	0	0
Whooping cough	135	51	43	176	47



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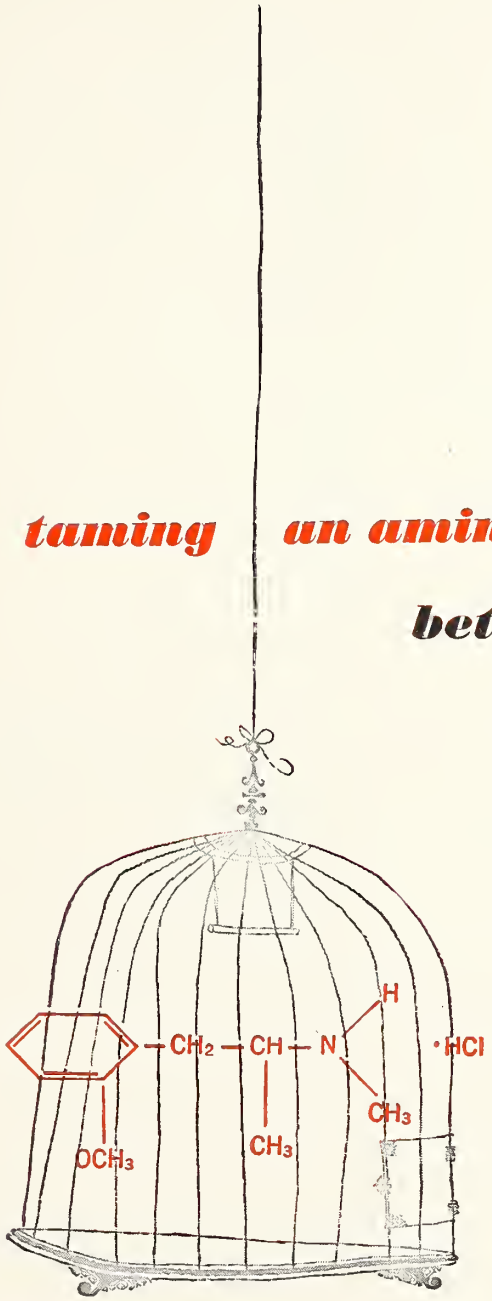
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1. Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.

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1	Herman T. Combs, Evansville	Dec. 31, 1953
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3	William H. Garner, New Albany	Dec. 31, 1952
4	Charles Overpeck, Greensburg	Dec. 31, 1953
5	A. M. Mitchell, Terre Haute	Dec. 31, 1951
6	W. U. Kennedy (Chairman), New Castle	Dec. 31, 1952
7	Roy A. Geider, Indianapolis	Dec. 31, 1953
8	E. H. Clauser, Muncie	Dec. 31, 1951
9	Wemple Dodds, Crawfordsville	Dec. 31, 1952
10	William H. Howard, Hammond	Dec. 31, 1953
11	Elton R. Clarke, Kokomo	Dec. 31, 1951
12	M. B. Catlett, Fort Wayne	Dec. 31, 1952
13	Kenneth L. Olson, South Bend	Dec. 31, 1953

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1.	William B. Challman, M.D., Mt. Vernon	W. C. Stover, M.D., Boonville	
2.	C. Philip Fox, M.D., Washington	J. S. Brown, M.D., Carlisle	Linton, 1952
3.	Joseph C. Dusard, M.D., Bedford	Eli Goodman, M.D., Charlestown	Spring Mill State Park, 1952
4.	Carl Henning, M.D., Hanover	Robert O. Zink, M.D., Madison	Madison, 1952
5.	Gilbert D. Rhea, M.D., Greencastle	Stuart R. Combs, M.D., Terre Haute	Greencastle, May, 1952
6.	F. B. Mountain, M.D., Connersville	Robert W. Kuhn, M.D., Wilkinson	Rushville, 1952
7.	E. M. Pitkin, M.D., Martinsville	Ralph V. Everly, M.D., Indianapolis	
8.	G. B. Wilder, M.D., Anderson	Warren Fisher, M.D., Anderson	Anderson
9.	Roland E. Miller, M.D., Lafayette	Hugh B. McAdams, M.D., Lafayette	Crawfordsville, May 24, 1952
10.	Frank G. Sink, M.D., Remington	H. E. English, M.D., Rensselaer	
11.	O. G. Brubaker, M.D., North Manchester	C. R. Herd, M.D., Peru	Wabash, September 19, 1951
12.	Wm. J. Gerding, M.D., Fort Wayne	James M. Burke, M.D., Decatur	
13.	Milo G. Meyer, M.D., Michigan City	O. E. Wilson, M.D., Elkhart	South Bend, November, 1951

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MODERN INFANT FEEDING: A SIMPLIFIED APPROACH

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AND

W. D. SNIVELY, JR., M.D.

EVANSVILLE

A simplified approach to the feeding of infants, used routinely for the past 15 years, is presented.

IN SURVEYING the history of infant feeding from early antiquity to the present era, one is impressed by two facts: First, that drastic and numerous changes have occurred in the practice of infant feeding, and second, that *change* has not always resulted in *progress*. The practices of the ancient Egyptians, for example, appear far superior to those of Europeans of many centuries later when viewed in the light of modern pediatric knowledge.

Toward the end of the nineteenth century an earnest effort was made to provide artificial formulas scientifically adapted to the needs of infants. A result of this attempt was the "percentage method" of infant feeding, which was precise to an impractical degree and immensely complicated. The percentage method was based on the belief that one or more elements of cow's milk could be harmful to the infant and that they should be included in the formula only in carefully calculated percentages.[1] The attempt of the method to incorporate slide rule precision in infant formulas led to rigid timing of the feeding intervals and volumetric determinations of individual feedings based on measurements of stomachs in infant cadavers.[2]

With the realization that infants are not robots to be fed identical amounts of nutrients on the basis of weight, age, and calculated stomach size, a more rational practice prevailed and the percentage method fell into disuse. Nevertheless, its unfortunate influences permeated medical practice so thoroughly that some have persisted to this day.

Standard ingredients are used: Cow's milk (either evaporated or fluid whole milk), water, and added carbohydrate, with a caloric distribution of approximately 15 percent of the calories from protein, 39 percent from fat, and 46 percent from carbohydrate. This corresponds rather closely to the average caloric distribution cited by Holt and McIntosh,[5] which has successfully withstood the tests of scientific examination and wide clinical use over the years.

Although our simplified formula does not attempt to simulate breast milk in percent composition, like breast milk it is kept constant in composition as long as the infant is on the bottle. Also, as in breast feedings, the infant determines the time interval and volume of each feeding, which means, of course, that he determines the total amount of formula received in any 24 hour period. The caloric value of the formula is approximately 18 to 19 calories per ounce, a concentration which does not overtax the digestive capabilities of the average infant, even with minor parenteral infections. Digestive disturbances are met simply by adding more water to the formula after cleanliness of preparation has been investigated. Increasing or reducing any one element such as sugar or fat has not proved useful except in occasional instances. Frequent juggling of the formula of the well infant is often poorly tolerated; the sick infant is even less tolerant of such manipulations.

The simplified formula is prescribed routinely for the newborn. Except for occasional adjustments of the dilution and total quantity, no changes are made during the formula-taking period.

FLUID

The formula is designed so that a liberal supply of fluid will be provided, about 3 ounces per pound body weight. A large portion of the daily requirement of fluid should be incorporated in order to dilute the protein, fat, and minerals of cow's milk, and to permit the addition of needed carbohydrate. Although the liberal fluid content of the formula may decrease the necessity for giving water, the latter should be offered several times daily—not necessarily midway between feedings. The drinking of water shortly before feeding time does not, as is widely believed, reduce the infant's desire for food.

PROTEIN

Adequate protein intake is of basic importance for optimum growth and development.[6] Both the lactalbumin and the casein of cow's milk are of excellent biologic quality. Fifteen percent of the calories of the simplified formula are from protein. While this provides generous protein, the amount is not excessive. Since the infant regulates the daily quantity of formula ingested, his exact protein intake cannot be predetermined. However, it has been our experience that the average infant on this regimen receives the protein allowance specified by the National Research Council.[9] After the third month, important amounts of protein are contributed by supplemental foods.

Cow's milk protein requires modification to adapt it to the digestive tract of the human infant. This is best accomplished by heat treatment such as evaporating or boiling. It should be emphasized that homogenized milk, like any fluid whole milk, should be boiled to assure bacteriologic safety and to improve digestibility.

FAT

The suitability of butterfat for the digestive tract of the infant has been amply demonstrated. The futility of attempts to imitate the fat of human milk is shown by observations which indicate that breast milk fat strongly reflects the mother's fat intake. It has been estimated that from 30 to 40 percent of breast milk fat represents unaltered dietary fat.[5]

In our formula, fat provides about 39 percent of the calories. A wide range of fat intake is well tolerated by normal infants; the breast-fed infant receives about 50 percent of his calories as fat. Although excessive fat may lead to digestive disturbances, none will question the necessity for a reasonable amount of fat in the diet of the healthy infant.

CARBOHYDRATE

Carbohydrate is the most readily assimilable source of energy for the infant. It exerts an important protein-sparing action by preventing formation of dextrose from amino acids. It is essential for the normal metabolism of fat, and serves to maintain the water balance of the body.

Controversy exists regarding the optimum level of carbohydrate in the infant diet. In practice, widely varying amounts are prescribed. Carbohydrate contributes as much as 65 percent of the total calories in formulas made from sweetened condensed milk, while it may provide as little as 28 percent of the total in simple milk-water mixtures without added carbohydrate.

Many clinicians are convinced of the value of high carbohydrate, low fat feedings for premature infants and for infants with disturbed fat tolerance.[8] It appears that infants are able to tolerate large amounts of carbohydrate provided it is not given over too long a period of time. Prolonged use of a formula excessively high in carbohydrate may cause hydrolability.[3]

Lack of carbohydrate in the diet has numerous ill effects. When inadequate carbohydrate is provided, the feeding of large amounts of fat will be accompanied by ketosis. Protein will be catabolized for energy purposes. Clinically, as Brennemann[7] pointed out, "If the carbohydrate is low and an excessive amount of cow's milk is given, there will normally result a condition . . . in which there is extreme constipation with dry, gray, foul, so-called soap stools. . . ."

At various periods in the history of infant feeding, attempts have been made to feed simple mixtures of cow's milk and water without added carbohydrate. In order for such low carbohydrate mixtures to maintain nutrition, supplemental carbohydrate must be provided. This, of course, necessitates spoon feeding soon after the newborn period. At this early stage of growth and development, the infant, while well equipped for sucking, is not yet developmentally ready for spoon feeding. This unreadiness for the spoon places a difficult, at times intolerable, burden on the new mother and may produce undesirable and lasting conflicts.

Needed carbohydrate should be incorporated in the formula. Experience indicates that this nutritional element should contribute about half the total calories. The formula thus constitutes a "complete food" for the suckling, and the necessity for unduly early spoon feeding is eliminated.

USE OF THE SIMPLIFIED FORMULA

Only water or a 5 percent simple sugar solution is given for the first day. If the infant is to be artificially fed, the simplified formula, made in the proportion of 1 tablespoon of Dextri-Maltose for each 2 ounces of evaporated milk and each 4 ounces of boiled water, is started on the second or third day. (If fluid whole milk is used, the proportion of milk and water is reversed, becoming 1 table-

spoon of Dextri-Maltose to 4 ounces of fluid whole milk and 2 ounces of water.) In the hospital this formula is given in specified amounts and at set intervals determined by the prevailing routine, which usually means that the newborn infant is fed every 3 or 4 hours. It would seem more desirable to feed the infant *when hungry* but this is not expedient with present-day limitations of facilities and personnel.

When the infant is sent home, a modified self-demand or self-regulating schedule is adopted. The mother is instructed to make up 24 ounces of formula either in the 1-2-4 (or the 1-4-2) proportions above mentioned. (See Table I.)

TABLE I*

Dextri-Maltose (tablespoons)	4	5	6
Evaporated Milk (ounces)	8	10	13
Boiled water (ounces)	16	20	26

The above simple table showing the three frequently used combinations of the "1-2-4" formula is given to the mother. The first column at the left covers the infant's early needs. As his needs increase, the mother prepares the formula in the increased multiples shown in the columns to the right.

* When individual feedings are employed, the simple proportions of 1 tablespoon of Dextri-Maltose to 2 ounces of evaporated milk to 4 ounces of water is convenient. The mother may wish to prepare single feedings when the feeding is used to supplement the breast, when traveling, or when refrigeration is limited.

We explain to the mother that our problem is to determine the number of times her baby should be fed in each 24 hour period. As a starter, she is instructed to divide the formula into 7 bottles. (Very young infants usually require 6 to 8 feedings in 24 hours.) The mother is instructed to feed the baby when hungry. Sometimes the small infant may take feedings at 2 hour intervals, then wait 5 or 6 hours before he shows a desire for the next feeding. To avoid too frequent feedings, the mother is advised not to offer the bottle oftener than every 2 to 3 hours and not to awaken the baby when he prefers a longer interval.

Sufficient total quantity is prescribed so that individual feedings will be generous. As the infant grows older the number of feedings required will become less; the day's formula is simply divided into the number of feedings the infant needs in 24 hours. The mother is instructed not to force the baby to empty the bottle. Dawdling is discouraged and the feeding period is limited to approximately 20 minutes. The infant should not be expected to take the same number of ounces at each feeding, and any formula remaining in a bottle should be discarded.

After the first weeks at home, it becomes apparent that more formula is needed. The mother is instructed to make up the 1-2-4 (or the 1-4-2 mixture) in the next multiple. (See Table I.)

When the multiple of 6 is arrived at, as shown in the third column in Table I, we suggest the use of 6 tablespoons of Dextri-Maltose, 1 can of evaporated milk (13 ounces), and 26 ounces of boiled water, merely for convenience sake.

Differences exist among infants of the same age as to number of feedings required daily. For example, the placid infant of 2 months may be happy with 5 feedings in 24 hours, while the hyperactive, fretful baby may need as many as 7.

Respect for the individual infant's needs as to number and volume of feedings is required for a psychologically sound method of giving the formula, as one of us pointed out in 1934.[4] In the first months, the mother adapts herself to the baby's routine. Surprising regularity is frequently established at a very early age by the infant. Later, as his developmental progress permits, the infant can be taught to adjust his routine to that of the family.

Modern life imposes some limitations on the self-regulating schedule. Unfortunately, some mothers are unhappy without a routine to follow, and an unhappy mother results in an unhappy infant. In such instances, we choose the lesser of two evils and provide the mother with a definite routine, based as much as possible on the infant's needs.

The formula in an approximate multiple of 6 is continued until near the end of the first year. A minimum of formula adjustments are resorted to. Occurrence of minor infections or digestive upsets usually requires only dilution of the 24 hour formula with water.

When infants are fed as above described, very little of what is loosely termed "colic" is seen. True colic, which has impressed us as an uncommon entity, appears unrelated to any formula or method of feeding.

SUPPLEMENTAL FOODS

Soon after the infant is home from the hospital, a powdered polyvitamin dispersion is added to the formula. While the formula is the primary food in the young infant's diet, he soon tolerates and needs a variety of foods. Proper time for addition of solid food depends upon the ability of the individual infant to accept spoon feedings. Some are able to do this as early as the end of the second month; others have difficulty as late as the fourth month.

Each supplemental food is started in small quantity and gradually increased in amount. Supplemental foods are never mixed with the formula. The aim in presenting semisolid foods early in the first year is to accustom the baby to foods of different flavors and consistencies and to teach him to recognize the spoon as well as the bottle as a source of food.

The first solid food is customarily offered at the end of the second or third month. The infant's digestive system readily adapts itself to solids that are primarily carbohydrate in nature, such as a precooked cereal. The educational function of the first solid food offered is of even greater impor-

tance than its nutritional contribution. Precooked cereals are readily prepared and can be fed in any amount desired without waste.

Pureed meats and vegetables are added at the end of the third to the end of the fourth month. A fruit such as ripe mashed banana, or one of the pureed fruits, is offered at the same time. This may be of value in preventing constipation. Cooked egg yolk is added from the end of the fourth to the end of the fifth month. It may be given hard or soft boiled or mixed with cereal. (See Table II.)

TABLE II

Food	Age
Powdered polyvitamin preparation	End of second week
Orange juice	End of first month
Precooked cereal Pablum Mixed Cereal Pablum Oatmeal	End of second or third month
Pureed meats Beef Pork Liver Veal Lamb Heart	End of third or fourth month
Pureed vegetables	End of third or fourth month
Fruit Ripe mashed banana Mashed apricots Mashed prunes Applesauce	End of third or fourth month
Cooked egg yolk	End of fourth or fifth month
Cottage cheese	End of fifth or sixth month

At about the sixth month, when a variety of foods are given and when more than one food is offered at a single feeding, the following combinations are used: Cereal and egg yolk; meat and vegetables; fruit and cottage cheese.

At about the tenth month, the transition from bottle to cup is started. The ordinary 1-ounce liquor glass lends itself admirably to this purpose due to its small diameter and capacity. It is more practical than a larger container or any special weaning device.

Strained foods are gradually replaced by finely mashed or chopped foods from the table. Weaning from strained foods poses a serious problem when it is carried out too late. If the infant is permitted to have strained foods much beyond the first year of life, he is reluctant to give them up. As a result, he may refuse food with lumps in it indefinitely and present a feeding problem for years.

The bottle is discarded at approximately the end of the first year, although some infants may voluntarily give it up sooner. Encouragement of the "bottle habit" after the first birthday may have unfortunate nutritional and psychologic results. Persistence of infantile feeding habits in the toddler does not permit him to act his emotional age.

As soon as bottle feeding is discontinued we begin a three meal routine. Boiled whole milk is given at mealtime. Only fruits and fruit juices are offered between meals; crackers, cookies and other tidbits are not permitted.

In many ways the one year milestone is significant. The mother should be given a preview of what to expect of her baby in the months to come. She should be forewarned that his feeding requirements and habits will change. His rate of growth will greatly diminish and he will not maintain his earlier engrossment in food. He will become interested in other things, will become assertive, and will begin to think for himself. When mothers are adequately prepared for the changes to come, many "growing up" problems of the runabout child are forestalled.

During the first year of life, the mother's attention is directed almost solely toward the child's physical development and physical needs. If she understands that these needs must change with the ever-changing rate of growth, she will be helped to sublimate her maternal instinct for getting food into her offspring and thus be able to devote more attention to his total "growing up" process.

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CYSTIC DISEASE OF THE LUNG

CASE REPORT

PAUL D. CRIMM, M.D., AND FREDERICK L. KIECHLE, M.D.*

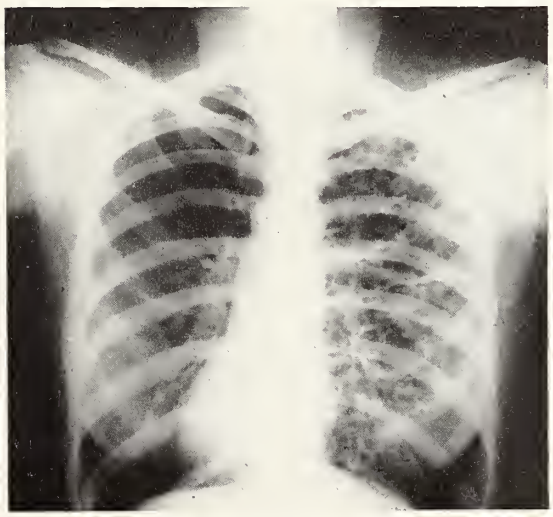
EVANSVILLE

THE case reported herein is one of congenital polycystic disease of one lung. Since it was confined to upper, middle, and part of lower lobes, extirpation of the entire lung was advisable. Bronchoscopic drainage of these cysts was of some benefit prior to surgical extirpation. This was used until the patient consented to have the lung removed. Figure I shows the radiograph prior to the bronchoscopy. Figure II shows many cysts filled partially with Lipiodol. Figure III is a radiograph taken one week following pneumonectomy. Figure IV is a radiograph taken after three thoracoplasties which were performed to close the residual pleural space. Figure V is a radiograph of another patient with just a solitary cyst. This patient is free from symptoms except when she has an acute cold.

CASE REPORT

The patient was a white female, age 26. The chief complaints were chronic productive cough, hemoptysis, and moderate orthopnea. First admission to hospital was in June, 1946. Considerable purulent material was aspirated from bronchi. She refused surgery. In December, 1949, patient was readmitted with complaints of productive cough, especially in the morning, hemoptysis, occasional night sweats, and orthopnea. Orthopnea was of one year's duration, and "cold" and productive cough had been worsening. In February, 1950, patient consented to a pneumonectomy.

Figure I



Radiograph showing annular rings in the right lung.

Past history revealed that she had measles and whooping cough in childhood. She had been told that measles "had settled in her lungs." She had "pneumonia" annually for the first eight years of life. Family history was noncontributory.

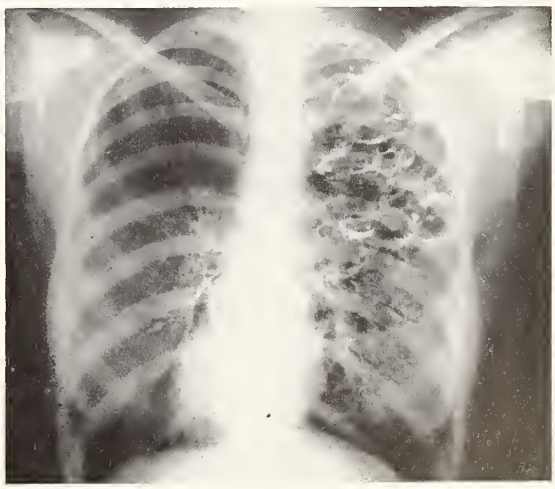
Physical examination revealed the following positive findings: Pulmonary osteoarthropathy was present. Many coarse and medium crepitant and musical rales and wheezes were heard throughout the right lung.

Laboratory examination: Sputum and bronchoscopy specimens were negative for acid-fast bacilli. WBC 6,750; eosinophils 1 percent, stabs 7 percent, segmenters 38 percent, small lymphocytes 7 percent, large lymphocytes 40 percent, monocytes 7 percent. RBC 3,100,000 with 46 percent hemoglobin (Sahli). Bleeding time was 7 minutes and coagulation time was 7¾ minutes. Urinalysis was essentially negative except for albumen, one plus. Occasional hyalin and finely granular casts were found postoperatively.

SURGICAL PROCEDURES

Endotracheal anesthesia of nitrous oxide and ether was used after induction with Sodium Pentothal. Patient was operated through a Rheinhoff incision. The right lung was removed and vessels individually ligated without incident of reportable interest. Dense adhesions were located medially and inferiorly, and thin adhesive bands were located superiorly, but medially attached to the mediastinum. Adhesions were separated. Six weeks fol-

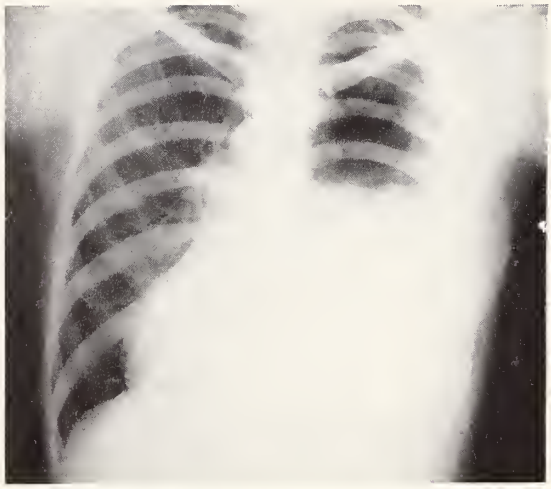
Figure II



Bronchogram shows lipiodol in cystic cavities.

*From Boehne Hospital, Evansville, Indiana.

Figure III



Radiograph following extirpation of right lung.

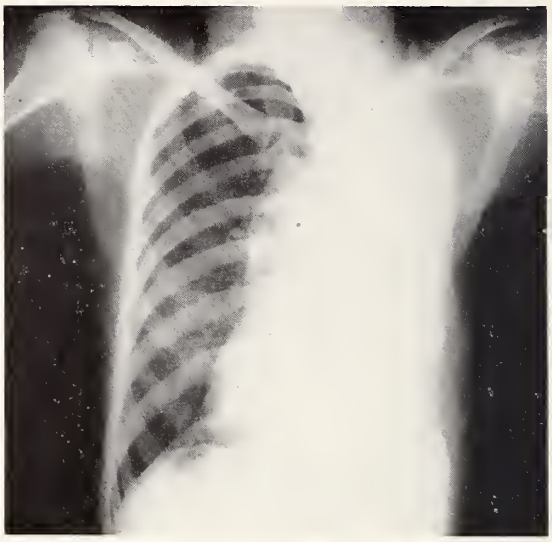
lowing pneumonectomy, thoracoplasties were performed to obliterate the thoracic space.

PATHOLOGY

Gross: Lower lobe exhibited somewhat reduced crepitation and a few cysts to gross inspection. The remainder of the lung tissue was studded with bosselations which were easily collapsed by pressure. Cut section reveals upper, middle, and portion of lower right lobes to contain innumerable cysts measuring from ca. 4 to 0.5 cm. in diameter, and filled with either air, serous fluid, or purulent semi-fluid material. Many of these cysts were located close to the periphery of lung. It was impossible to demonstrate bronchial communications. Intervening lung tissues were atelectatic and fibrotic. Uninvolved portions of lower lobe were slightly atelectatic and of dark red, somewhat congested appearance.

Microscopic: Larger cystic spaces are seen to be lined with epithelium, sometimes folded in papillary pattern, and sometimes pseudostratified, ciliated and columnar. Larger cystic spaces may contain homogeneous eosinophilic exudate with many polymorphonuclear leukocytes. Larger cystic spaces are surrounded by imperfect, stretched, and at times irregular muscle bundles, occasionally including large zones of smaller cystic structures lined with large, sometimes proliferated cuboidal cells, and often containing large, sometimes pigmented phagocytes. Fibrous tissue stroma of cyst wall may contain lymphoid and plasma cell infiltration. Vascular fibrous tissue dominated the remaining lung tissue with occasional foci of lymphoid infiltration. Areas of smaller cysts similar to those described in the wall of larger cysts are not infrequent. Atelectasis, proliferative fibrosis, edema, erythrocytic infiltration, and degeneration may be found in a few remaining alveolar areas. Many smaller blood vessels are the site of obliterative endarteritis.

Figure IV

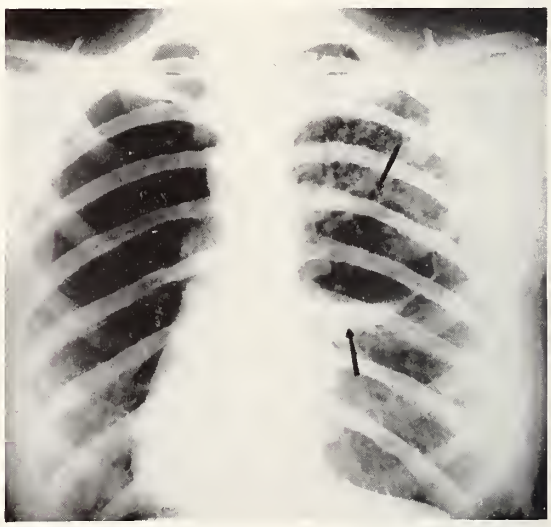


Right pleural space closed by three thoracoplasties.

COMMENT

Congenital disease of the lung is not seen too frequently. The earliest reference to this condition was reported by Thomas Bartholinus in an article written by Oughterson and Taffel.[1] Koontz[2] described it in 1925, and collected 108 cases from the literature. Since 1925, Wood[3] and others (Schenck,[4] Maier,[5] Smith,[6] Sellors,[7] and Willis and Almeyda[8]) have written extensively on this subject. In 1937 Schenck[4] stated that 321 cases of cystic disease of the lung had been reported since the original descriptions.

Figure V



Bronchogram shows solitary cyst partially filled with lipiodol. Solitary cysts with adequate drainage like the one shown in Fig. V do not warrant surgical intervention. This patient, another case we encountered, has a cyst which seldom contains pus except when patient has an acute "cold."

Dickson et al,[9] in 1946, reported 42 surgically treated patients with cystic disease of the lung. Their classification includes both the congenital cyst and the acquired cyst of the lung. In 1944 Madsen and Pirkle[10] described a diagnostic procedure which could be used if bronchoscopy is not advisable or available. In 1938 Dubrow and Wynne[11] reported a case of cystic disease which was confused with pneumothorax.

The essential histology of congenital cysts of the lung lies in the uniformity of the lining membrane which has the character of bronchial epithelium. The other structures, like cartilage and smooth muscle, are arranged irregularly.

In this case the diagnosis was easily made from the ordinary radiograph, but was confirmed by bronchoscopy with bronchograms. The presence of large numbers of cysts confined to the major portion of the right lung warranted its entire removal. The patient's symptoms were immediately relieved by pneumonectomy.

CONCLUSIONS

1. A case of congenital cystic disease of the right lung with successful surgical treatment is presented.
2. Surgical extirpation of one or more lobes is the ideal treatment for congenital cystic disease of the lung.

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PHYSICIANS' HELP ASKED IN HALTING USE OF NOSTRUM

U. S. Food and Drug Administration is asking help of physicians in warning diabetics against a remedy being mailed into this country from Mexico which FDA describes as "worthless and extremely dangerous if employed as a substitute for insulin." If doctors know of diabetics who have the preparation they may communicate the information to FDA which will contact the patients immediately. It is advertised as Cacalla Composita Mexican Indian Root and is being offered by "Mexican Indian Root Co., Mexico City," under the name of Dr. Miguel C. Martinez, general manager. One-inch advertisements have appeared in newspapers and magazines in about a dozen cities and direct mail advertising also is being used. It is priced at $15 and $25 cash in advance. Among 20 individual packages intercepted were shipments destined for all parts of the country. AMA's Bureau of Investigation first called the situation to the attention of FDA.

HOMOLOGOUS SERUM HEPATITIS IN A VERY YOUNG INFANT

JACK TROY, M.D.

WHITING

VIRAL HEPATITIS occurred during the Civil War and was known to occur in succeeding wars. However, when 28,585 cases were reported in the United States Army in 1942 following the use of Yellow Fever Vaccine, the condition took on serious import.

Homologous serum jaundice occurring following injections of blood or blood derivatives has been differentiated from infectious hepatitis. The former is an important problem in infancy and childhood because of the frequency with which blood is used in the treatment of sick children. Yet few cases have been reported in infants. Homologous serum hepatitis has a high mortality in infants. Moloshok, Karelitz and Strauss[1] reported eight cases with five deaths. Traisman, Wheeler and Fager[2] reviewed the nine cases which had occurred in Children's Memorial Hospital in Chicago. Five of these had died. Several other cases have been reported in infants.[3, 4]

The following case is reported because of the very young age of the patient and because of the symptomatology and pathology referable to the urinary, gastrointestinal, and nervous systems.

CASE REPORT AND AUTOPSY

K. B. was born on December 13, 1949, at 6½ months' gestation. She was one of twins. The other twin weighed 2 pounds 9 ounces, and died of prematurity.

K. B. weighed 2 lbs. 10½ oz. at birth and did well on an Olac formula, receiving Drisol and vitamin C as supplements. On January 24, 1950, her hemoglobin was 8 grams and R. B. C. was 3,000,000. A transfusion of 35 cc. type "A" Rh positive compatible blood was given. The baby did well and on February 4, 1950, the R. B. C. was 2,630,000. A second transfusion of 50 cc. of whole blood was given. The baby at this time weighed 5 lbs. and was discharged from the hospital.

Following discharge, the baby appeared perfectly normal until March 20, 1950, when a sudden bout of diarrhea and vomiting occurred, followed by dehydration. The mother reported that some of the stools were light in color.

Despite treatment with Kaopectate and reduced food intake, the baby was admitted to the hospital on March 22, 1950, with very severe dehydration. The fontanelle was so depressed that it admitted the thumb. The baby's skin was mottled and cyanotic. Respirations were rapid and dyspneic. The liver was enlarged to three fingers below ribs. The spleen was palpable, as were both kidneys.

The baby was immediately put in an incubator and given oxygen and lactate Ringer's Solution with Alidase. This was followed by a transfusion of 70 cc. of whole blood, vitamin K, 5 mg. daily, and procaine penicillin, 400,000 units I. M. daily. R. B. C. at this time was 3,000,000. The W. B. C. was 19,650 with 78 polys and 22 lymphs. Because the dehydration and acidosis did not respond to the above treatment, 20 cc. of 5% sodium bicarbonate was given I. V. and followed by 200 cc. of 1/6 molar sodium lactate solution with glucose.

On March 24, 1950, the dehydration and acidosis were not apparent clinically. Stools were normal. Examination of the blood and urine was normal. However, at this time the baby began to show signs of cyanosis and twitching. She did not eat well, and had some bleeding from the nose and rectum. The laboratory work showed a 3 plus albuminuria, N. P. N. of 90, icterus index of 15, and a calcium of 9.5. Because of the possibility of potassium depletion, 100 cc. of Darrow's Solution was administered. There was no change in the baby's condition.

At this time the diagnosis of homologous serum jaundice was considered. Fifty-five days had elapsed since the first blood transfusion (the usual incubation period for homologous serum hepatitis is 60-120 days). A subsequent check of the blood used for the transfusion revealed that the donor had given no history of jaundice.

On March 25, 1950, the baby developed signs of decerebrate rigidity (tonic neck reflex and extensor spasm). The abdomen was distended. Fundi appeared normal. Spinal fluid revealed no cells and subdural taps revealed no blood or fluid. Cisternal puncture revealed normal fluid. The baby continued downhill and died on the evening of March 25, 1950, following convulsions.

Autopsy performed on March 26, 1950, revealed the following:

Gross Description

Body was that of a 3 month old female infant, weight 31.00 grams, which appeared in a fair state of nutrition. The skin turgor was fair. There was marked distention and protuberance of the abdomen. There was a slight icteric tinge to the skin and sclerae. The anterior fontanelle was prominent and slightly depressed.

Chest

The lungs were normal except for evidence of congestion and atelectasis of the lower lobes.

The thymus was extremely small in size, weighing no more than a gram and a half and was composed of typical grey lobulated tissue.

Heart: The heart exhibited no anomalies. The left ventricular wall was distinctly hypertrophied, thick and firm, and the myocardium was pale grey in color. There was a small subendocardial hemorrhage in the left ventricle.

Abdomen

The loops of bowel exhibited tremendous distention, reaching a diameter up to 2 cm. in areas. About 15 to 20 cm. of small bowel in the distal jejunum was discolored purple-red due to hemorrhage in the wall.

The liver was somewhat reduced in size, weighed 140 grams and was lemon-yellow in color. The parenchyma was very firm in consistency and cut with some increased resistance. On cut surface the normal markings were obscured and there was mottling, with areas of purplish discoloration.

The spleen appeared slightly enlarged, measuring about 1½ to 2 times the normal size. There were small purple-red areas of infarction in the pulp of the spleen.

The suprarenals were normal.

The kidneys were distinctly enlarged, measuring about 2 times the normal size. The parenchyma was pale and yellow in color and mottled with small areas of purple-red. On cut surface the entire kidney appeared swollen and edematous and the markings were obscured.

Head

Exposure of the brain revealed the brain to be distinctly edematous with flatting of the convolutions and reduction in the size of the sulci.

Anatomic Diagnosis

1. Subacute diffuse virus hepatitis (homologous serum)
2. Hemorrhagic diathesis
3. Edema of the brain
4. Atelectasis of the lower lobes of both lungs
5. Edema and swelling of the kidneys
6. Concentric hypertrophy of the left ventricle of the heart
7. Splenomegaly
8. Tympanitis

Microscopic Description

Brain—Section of the brain revealed moderate edema of the parenchyma with moderate infiltration with inflammatory cells in some areas. This cell infiltration appeared restricted to the white substance and consisted of few polynuclears and an increase in glial cells.

Liver—Revealed striking advanced degenerative changes so that the normal architecture was completely obscured. Only a few small islands of recognizable liver cells remained and these cells exhibited marked fatty degeneration, so that only fragments of cytoplasm were maintained. The remainder of the liver exhibited complete cellular degeneration and necrosis.

SUMMARY

1. A case of homologous serum hepatitis in a three-month-old infant is presented. Symptoms began fifty-five days after a blood transfusion.

2. The outstanding clinical features were (a) diarrhea with severe dehydration; (b) evidence of kidney damage; (c) bleeding; (d) terminal signs of decerebrate rigidity.

CONCLUSION

Homologous serum hepatitis, considered rare in infancy, is being reported more and more frequently. It is a serious disease in infants; the reported mortality rate is about 50 percent.

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The Instructional Courses of the 1951 Session will present discussions of "ACTH and Cortisone," "Common Skin Diseases," "Minor Home, Farm and Factory Emergencies," and "Management of the Elderly."

BILIARY TRACT SURGERY IN A SMALL VOLUNTARY HOSPITAL*

Mell B. Welborn, M.D.

EVANSVILLE

IT OCCURRED to us that it would be interesting to know what our experience had been with a consecutive series of patients undergoing surgery on the biliary tract in a relatively small general hospital. Most studies of this type have come from the universities and large teaching hospitals, and the results of their work are well known, but very little is known of the results obtained in the smaller hospitals. It was felt that these might be interesting and that a valid basis for comparison of results might be reached. With these thoughts in mind, a study was undertaken beginning with a recent series of cases, July 1, 1947, and continuing through December 31, 1950. In carrying out this study it has been our purpose to place particular emphasis on the number of patients undergoing surgery, the number and types of operations carried out, the operative findings, the hospital mortality and the complications. A study of associated systemic disease was also done in order to illustrate the seriousness of the surgical problem in many patients.

MATERIALS AND METHODS

All patients undergoing surgery on the biliary tract by members of the Welborn Clinic Staff from July 1, 1947, through December 31, 1950, were chosen for study. These patients' charts were reviewed by the writer, and an individual study card designed to contain the following information: The patient's initials, hospital case number, age, sex, type and date of operation, the operative findings, including the presence or absence of stones in the gallbladder or common duct, or of a neoplasm of the extrahepatic biliary system or head of the pancreas. Data were also recorded regarding the presence of clinical jaundice at the time of exploration, associated diagnoses, hospital complications and deaths. A patient undergoing more than one operation, but in different years, was counted as one patient each year that the operation was undertaken.

*From the Surgical Service of the Welborn Clinic and the Welborn Memorial Baptist Hospital.

RESULTS

Table No. 1 shows the number of patients by years, the number of operations carried out on these patients, the average age, the complications, and the number of hospital deaths. The time involved was the last six months of 1947, and 12 months each in 1948, 1949, and 1950, for a total period of time in months of 42. Thus it is seen that during this interval a total of 252 patients underwent 260 biliary tract operations with a total of six hospital deaths for a patient mortality rate of 2.4 percent. These six deaths will be discussed in detail later in this paper.

TABLE No. 1

Year	No. of Patients	Average Age	No. of Operations	No. of Complications	No. of Deaths
1947	14	55	14	0	1
1948	72	53	73	3	2
1949	67	50	68	3	0
1950	99	54	105	3	3
Total	252		260	9	6

Only the last six months of 1947 are included. For details, see text.

Table No. 2 shows the number of patients by years having stones in the biliary tract or a neoplasm. Only those patients having had histological evidence of neoplastic disease were included. There were a small number of deeply jaundiced patients with nodular heads of the pancreas, in whom it was impossible to determine, either by gross or tissue examination, whether the

TABLE No. 2

Year	Total Patients	Stones in Biliary Tract	Stones in Common Duct	Percent Having Stones in Biliary Tract	No. of Patients With Neoplasm of Biliary Tract
1947	14	13	1	93	1 (Ca. Ampulla)
1948	72	55	10	82	3 (Ca. Gallbladder)
1949	67	59	10	82	4 (1 Ca. Gallbladder) (1 Ca. Bile Duct) (2 Ca. Ampulla)
1950	99	85	16	86	5 (3 Pancreas) (2 Gallbladder)

This table was designed to show some of the pathological lesions encountered. An average of 86 percent of the patients were found to have stones. The carcinomas of the pancreas were in the head and obstructed the common bile duct.

TABLE No. 3
TYPE OF OPERATION PERFORMED

Year	Total No. Pts. and No. of Operations	Simple Drainage	Cholecystectomy	Exploration Common Duct	Other
1947	14- 14	3 (21%)	9 (64%)	3 (21%)	Single Stage Radical Pancreatoduodenectomy 1
1948*	72- 73	8 (11%)	62 (86%)	15 (21%)	Cholecystojejunostomy 1
1949†	67- 68	8 (12%)	55 (82%)	15 (22%)	Biopsy Gallbladder 1
					Two Stage Pancreatoduodenectomy 1
					Excision Ca. Papilla 1
					Cholecystojejunostomy 1
1950††	99-105	15 (15%)	78 (79%)	25 (26%)	Cholecystojejunostomy 1
					Cholecystojejunostomy 1
					Cholecystojejunostomy 1
					Cholecystojejunostomy 1
					Choledochoduodenostomy 1
					Biopsy Gallbladder 1
Totals	252-260	34 (13%)	204 (81%)	†††58 (23%)	

* Two patients with previous cholecystectomy had exploration of the common duct. One patient had cholecystectomy with closure of cholecystoduodenal fistula and one had combined supra- and transduodenal exploration of the common duct.

† Two patients had combined supraduodenal and transduodenal exploration of the common duct.

†† One patient had splenectomy for congenital familial hemolytic jaundice and cholecystectomy for stones.

Two patients had combined supraduodenal and transduodenal exploration of the common bile duct.

††† Sixty-four percent of those having the common duct opened had stones. Some of the remainder had other pathological lesions without stones, such as stenosis of the papilla of Vater.

This table illustrates the type of operative procedure performed. See footnotes and text for details.

process was due to chronic pancreatitis or a neoplasm. This group of patients represents a troublesome surgical problem and is being studied in some detail at this time. Many of the patients in this series had longstanding chronic disease of the gallbladder with superimposed acute inflammation; some of them had been operated previously, and a few of these had external biliary fistulas, occasionally without gallstones. The entire group had rather serious and complicated local pathological changes in the biliary tract, but there were a few with simple uncomplicated cholelithiasis. Many of the patients, in addition, had serious complicating systemic disease, such as hypertension, diabetes or coronary artery heart disease.

Table No. 3 lists the various types of operative procedures carried out. Thus it is seen that the 252 patients had a total of 260 operations, 13 percent had cholecystostomy, 81 percent had cholecystectomy, and the remainder had some other procedure, such as radical pancreatoduodenectomy or the establishment of an internal biliary fistula. The common duct was explored in 23 percent, stones being found in 64 percent of those undergoing exploration. Cholecystostomy was done when the local pathological changes so distorted the normal anatomical relationships that safe removal seemed precluded and, in general, not because of the poor condition of the patient. The footnotes to Table 3 indicate the various other types of operative procedures employed, occasionally combined also with drainage or removal of the gallbladder.

Table No. 4 lists the associated operations that were done as an incidental procedure to those on the biliary tract. There were 20 appendectomies, four umbilical herniorrhaphies, one cauterization of the cervix and one oophorotomy. We were surprised to find that we had done this many, as it is our feeling that seldom should one add the risk, admittedly small, of an incidental operative procedure.

TABLE No. 4
ASSOCIATED OPERATIONS OTHER THAN THOSE ON THE BILIARY TRACT

Year	Total No. Patients	Associated or Incidental Operation	Type of Operation: Appendectomy	Umbilical Hernia	Other
1947	14	2	2	0	0
1948	72	8	6	2	0
1949	67	15	11	2	2*
1950	99	1	1	0	0
Total	252	26	20	4	2

* Cauterization Cervix 1
* Oophorotomy 1

The most common operation incidental to that on the biliary tract was appendectomy. These associated procedures should be kept to a minimum.

Table No. 5 was designed to show some of the more serious systemic disorders associated with the local disease process in the gallbladder and bile ducts: patients over the age of 70 years (this number being taken as an arbitrary figure); those being very obese, and those having jaundice at the time of surgery were counted as having a complicating associated disease. It is seen that 129 patients, or 47 percent of the total, had at least one, and some several, associated systemic lesions. The footnotes to this table list some of the more

TABLE No. 5
ASSOCIATED SYSTEMIC DISEASE AND AGE

Year	Total Patients	Pts. With Systemic Disease	Over 70 yrs.	Obesity	Hypertension and Cardiovascular Disease	Diabetes	Jaundice	Other*
1947	14	6	1	0	3	1	4	3
1948	72	35	6	16	14	0	9	13
1949	67	33	10	2	18	1	11	13
1950	99	55	14	10	23	6	19	11
Total	252	129	31	28	58	8	43	40

* 1947. One patient with cataract, one chronic alcoholic, one with previous cholecystostomy and incisional hernia.

1948. Two patients with umbilical hernia, one with incisional hernia, one each with senile osteoporosis of the spine; severe morphine addiction; perforated mucocele of the appendix; pregnancy, 5 months; dermoid of ovary; non-toxic adenoma of thyroid gland; carcinoma breast; deafness; kidney stone; treated carcinoma of cervix.

1949. One each with umbilical hernia; pregnancy six months; pregnancy at term; colostomy, secondary to radical resection rectal carcinoma; Parkinson's Disease; postoperative hernia with external biliary fistula; renal calculus; syphilis; treated endometrial carcinoma; multiple sclerosis; myxedema; prostatic hypertrophy, and pulmonary emphysema.

1950. One patient each with blindness; cataract; duodenal ulcer; previous nephrectomy; chronic alcoholism; prostatic hypertrophy; uterine prolapse; convalescent fracture femoral neck; pregnancy, 3 months; uterine prolapse and positive serology.

An effort was made to illustrate some of the serious systemic diseases associated with the local lesion in the biliary tract. See the footnotes and text for details.

common disorders encountered, and are self-explanatory.

There were nine complications in the 260 operations, none of them resulting in the death of a patient. There were no operative injuries to the duct system. The most serious untoward events were three wound eviscerations, all of them being closed with through and through steel wire, with recovery. It should be emphasized that the hazards of atelectasis, urinary tract infections, and peripheral venous thromboses are ever present, and that we feel these serious complications can be prevented by alert and energetic postoperative care.

DEATHS

There were six deaths in this consecutive series of 252 cases. These will be briefly summarized. The first one was a 59 year old, white female, with deep obstructive jaundice. A one stage radical pancreatoduodenectomy for carcinoma in the ampullary region was carried out. The afternoon of the day of operation her temperature was 108° F., and she expired in 48 hours. Autopsy revealed no technical faults, no peritonitis, death being due to hepatic failure.

The second death was a 76 year old, white female, with acute calculous cholecystitis and hypertension. Cholecystectomy was easily accomplished, but the patient failed to regain consciousness after surgery, and presumably died from a cerebral hemorrhage.

The third, a white female, aged 71, had simple drainage of the gallbladder with removal of stones for acute cholecystitis. She was deeply jaundiced. The liver was firm and hard. She grew progressively worse and died with a high fever, presumably from liver failure.

The fourth, aged 81, was an emaciated white male with deep jaundice and extensive carcinoma of the head of the pancreas. Death occurred in the hospital four weeks following cholecystojejunostomy, apparently from the combined debilitating effects of the malignancy and his advanced years.

The fifth death occurred in a 61 year old white male, who had undergone cholecystectomy and choledocholithotomy 14 days prior to his death. He did unusually well until his seventh day, at which time he complained of vague nausea and of not feeling quite well. On the day of his death he suddenly had a convulsion. His pulse rate was counted at the wrist at 20 beats per minute. An electrocardiogram showed changes indicative of a recent myocardial infarction. The diagnosis was that of a Stokes-Adams syndrome. Death ensued a few hours after this episode.

The sixth and last death in this series occurred in a white female, age 71, who had cholecystectomy and choledocholithotomy. She was jaundiced prior to surgery. She was doing well but died suddenly on her fifteenth day from what was thought to be a coronary occlusion.

COMMENT

It will be seen that there were three deaths from cardiovascular accidents, one from carcinomatosis, and two from hepatic failure; one occurring after simple drainage and the other after radical pancreatoduodenectomy. Four of the six deaths occurred in patients over 70 years of age. No patient died from wound, pulmonary or urinary tract complications, nor were there any injuries to the common bile duct. The mortality among the patients undergoing cholecystectomy was 1.5 percent (three deaths in 204 patients), the overall hospital rate for all cases being 2.4 percent. A breakdown of the cases into acute and chronic ones was purposefully avoided for this study, since what the surgeon may see and describe clinically as an

acute cholecystitis may be interpreted as a chronic one by the pathologist.

The mortality for operations on the biliary tract has been reported as varying from slightly less than one to more than 10 percent, the variation in some measure, at least, being due to different classifications of the type of problem under study. For instance, Glenn[1] reported a mortality of 2.8 percent in a group of 586 patients undergoing surgery for acute cholecystitis. Marshall[2] reported a mortality of .9 percent in a group of 1,104 cases having cholecystectomy for stones. Apparently he did not include those having cholecystostomy, a group in whom the mortality is usually higher due to the fact that this type of operation is apt to be employed only in those who are very acutely ill, or represent some other serious problem involving a high risk. Glenn[1] reports a mortality of 6.1 percent in 205 patients who were over 50 years of age. The deaths in our consecutive series of 252 patients were all above the age of 50, and in four of the six were above 70 years of age.

It should be emphasized that whether a hospital be large or small, certain basic requirements must be met before an acceptable mortality and morbidity rate can be had. Dependable x-ray and pathological laboratories are essential. Perhaps no factor is as important as that of good anesthesia, and perhaps in no other region, with the exception of the heart or lung, is it so necessary to have a good anesthetist. The surgeon must have well trained assistants, adequate in number, accustomed to working together as a team. The patient must be carefully watched during his postoperative course by trained, alert observers, who understand how to prevent or manage postoperative complications. It should be understood that this report is not being written to show that biliary tract surgery can be safely carried out in the small hospital, but rather that regardless of the size of the hospital, certain basic requirements, some of which were enumerated above, must be had.

SUMMARY AND CONCLUSIONS

A consecutive series of 252 patients undergoing 260 biliary tract operations by members of the Welborn Clinic Staff is reported. Thirteen patients had malignancies involving the gallbladder, extraheptic bile ducts, the ampulla, or the region of the head of the pancreas about the ampulla, and 212, or 86 percent, had stones in the biliary tract. Thirteen percent had cholecystostomies, 81 percent cholecystectomies, and 23 percent had exploration of the common bile duct, stones being found in 64 percent of those undergoing exploration. There were 12 miscellaneous procedures, such as radical pancreatoduodenectomies and cholecystojejunostomy. Several patients had combined supraduodenal and transduodenal exploration of the common bile duct. There were six hospital deaths, four of the six being above 70 years of age. Three of the deaths were due to cardiovascular accidents, one to carcinomatosis, one to liver failure in a patient undergoing single stage radical pancreatoduodenectomy, and one to liver failure in an elderly patient having cholecystostomy. The mortality rate in the 204 patients undergoing cholecystectomy was 1.5 percent. There were no operative injuries to the common bile duct. The necessity for basic diagnostic facilities, sound anesthesia, and an adequate number of trained assistants accustomed to working with the surgeon as a team is stressed.

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The Instructional Courses of the 1951 Session will present discussions of "The Management of the Neurotic," "Diagnosis and Management of Common Gynecological Problems," and there will be demonstrations of diagnostic, physical and of neurological examinations.

PYLORIC STENOSIS IN IDENTICAL TWINS: A CASE REPORT

JOHN B. WELSH, M.D.

ANDERSON

PYLORIC STENOSIS is generally considered to be congenital in origin but evidence as to its hereditary nature is less clear-cut.[1, 2] The first instance in twins was reported in 1924, each of monovular twins being affected.[3] An hereditary factor was suspected by Cockayne in two reports of pyloric stenosis in cousins.[4] The high incidence in males, particularly first-born, is well known, although evidence for a sex-linked, genetically determined etiology is lacking. In the fourteen cases of monovular twins so far reported, both members have had pyloric stenosis twelve times (85.7 percent); only one member on two occasions (14.3 percent). On the other hand, of twenty-four instances of pyloric stenosis involving binovular twins, pyloric stenosis occurred in both members in only two cases (8.4 per cent), only one being involved in the other twenty-two (91.6 percent).[5, 6, 7, 8]

The following case is presented as additional evidence of a genetically determined etiology of pyloric stenosis.

REPORT OF CASE

"A" and "B," twin boys, were delivered on December 2, 1950, at St. John's Hospital, at term after an uneventful gestation. Labor was of five and one-half hours duration. "A" was a right occiput anterior presentation. Episiotomy was done under intravenous Evipal anesthesia, and outlet forceps were used. Approximately four minutes later, "B" was delivered spontaneously by breech presentation.

Only one placenta was present; the membranes were not dissected to observe the chorionic layer. "A" weighed five pounds, "B" five pounds, twelve ounces. Their neonatal course was uneventful and their appearance was noted to be identical.

At approximately three weeks of age, both babies began to vomit. Trial with thickened feedings and atropine did not control the symptoms and they were admitted to the hospital on January 5, 1951. "A" had gained from five pounds to six pounds, two ounces, his vomiting was less marked and he had fewer gastric waves than "B." The latter had gained only from five pounds, twelve ounces to six pounds, one ounce, and had active projectile vomiting with prominent gastric waves. Pyloric tumors were palpated in both infants during their preoperative course. After preliminary hydration with hypotonic glucose in saline subcutaneously the babies underwent surgery on January 7, 1951. In each case the terminal pylorus was markedly hypertrophied, extending at least three centimeters in length. A Fredet-Ramstedt operation was done on each baby. Glucose was given by mouth at twelve hours and condensed milk feedings begun at twenty-four hours postoperatively. Their course was essentially uneventful and the babies were discharged on January 15, 1951, "A" weighing six pounds, four ounces, "B" six pounds, eleven ounces. Their subsequent development has been satisfactory.

SUMMARY

Because of its uncommon occurrence and possible relation to a genetic etiology of the entity, the fifteenth recorded occurrence of pyloric stenosis in monovular twins is presented.

Accumulated evidence indicates that pyloric stenosis tends to occur in both of monovular twins, but in only one of binovular twins.

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PHYSICIAN-PATIENT RELATIONS

ONE of the most important functions of a professional organization is the maintenance of moral standards among its members. All professions, and the medical profession in particular, are distinguished by the high order of integrity and honesty which serve as a daily guide for the practice of its followers.

In this imperfect world there are a few whose conduct at times falls short of the ideal. Unfortunately, those doctors who violate our code of ethics bring criticism on the entire practice of medicine out of all proportion to their numbers.

The good that doctors do is always appreciated and discussed. However, "bad news travels fast," and often the erring ways of one of our colleagues will be publicized in such a way as to reflect on us all.

That such situations arise infrequently is evidenced by the experience of the state association's Committee on Physician-Patient Relations. This committee, under the chairmanship of Dr. Claude S. Black, has adjudicated only nine complaints in its first year. Fifty-some complaints have been received, but the majority of them are too nonspecific to allow investigation.

Many of the complaints submitted proved, on inquiry, to be the result of misunderstandings between the doctor and his patient. Most of these were in the matter of fees.

In most cases amicable settlement was achieved by the ordinary process of explanation. In other instances the committee has felt that the physician in the case was at fault.

No matter how few and far between these examples of poor physician-patient relations are, it is extremely important that their incidence be kept at a minimum. Each one, when it occurs, is magnified by wide circulation and creates a bad impression, even though it may have resulted from an oversight or unintentional action on the part of the doctor.

THE BIG MEETING

THE WRITER is not addicted to conventions and such gatherings, but he always attends the state medical meetings and he went to the A.M.A. convention at Atlantic City this year. He always enjoys the company of other doctors, whether on "business" or pleasure, and both could be had at Atlantic City, in abundance.

There, on all sides, was a fine group of physicians, who were well shepherded in the enormous auditorium by a well-prepared system. Row on row of the finest type of scientific exhibit, each with one or more attendants (usually the "author"); a system of almost continuous scientific movies; and then an entire floor of technical exhibits, including a most enjoyable as well as instructive, demonstration by color television, were there, all day, every day, for the edification and delight of the said physicians. Add to this a comprehensive program of scientific papers of a high order of excellence, and you have a medical meeting worth anyone's time.

As for the entertainment, it was ample, although it must be said that the weather, for the most part,

was disagreeable. What transpired in the House of Delegates is reported elsewhere. Our own Ray Smith and his pal Waggener were there, helpful as usual to any Hoosier doctor in distress, or just plain sociable, p. r. n.

The meeting is now weeks behind us, but we are still impressed by the combination it presented of gigantic size and high quality. It made us feel a lot better about that little matter of A.M.A. dues.

A. W. C.

HOOSIER DOCTORS—ATTENTION!

THE BLUE SHIELD plans in many states are on a so-called "service" basis, where participating physicians agree, by contract with the insurance company, to accept the latter's allowance as payment in full for services rendered to subscribers having incomes below a certain level. In the states with a plan operating on a cash indemnity basis, efforts are being made to change this to the service basis. This was attempted last year in Indiana, and the following quotation is from a report of the Medical Economics Committee of the Kentucky State Medical Association:

> Our Committee is of the further opinion that as soon as it is economically feasible our Plan should be changed from a cash indemnity basis to a service contract as has already been done in many other states.
>
> * * * *
>
> It has been the experience in other states that such a contract is more satisfactory to the subscriber and to the physician. The subscriber likes it because he has nothing further to pay. Physicians like it since they can collect more for services rendered to persons with low incomes.

This sounds very pleasant, indeed, but let us remember—not all is gold that glitters. Last November, the Connecticut State Medical Society met and discussed changes in its service contract, promulgated by Connecticut Medical Service, the corporation which conducts the scheme and with which the participating physicians make the contract. Read these few excerpts from the published minutes of that meeting (*Connecticut State Medical Journal*, March 1951) and you will have food for thought:

> Dr. Davis. I would like to comment on one section of the report. Dr. Danaher says that in November 1949 the Professional Policy Committee polled the various surgical specialties in the State, and I can certify that that is true with respect to obstetrics and gynecology, because I am secretary of the organization that met with Dr. Middlebrook, composed of obstetricians and gynecologists from all over the State. At that meeting Dr. Middlebrook presented this thing, and he was at that time, and I presume still is, a member of the Professional Policy Committee. He was not willing to accept any single suggestion, criticism, correction or addition, not one single one.
>
> He was willing to allow us to fiddle around with the figures in the schedule, and, Gentlemen, that is all. Thank you.
>
> Dr. Cullen. There is another thought I had in mind. I wonder if the Professional Policy Committee together with the representatives of the Blue Cross have a right to change this fee schedule without first bringing it up before this House of Delegates. It seems to me that is a rather dangerous procedure.
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> * * * *
>
> Dr. Danaher. I think one thing we ought to clarify here, and that is that the contract between the corporation, Connecticut Medical Service, is with the participating physicians and not with the Connecticut State Medical Society. But when this thing is finally passed and approved by the proper bodies, each participating physician gets a copy of the changes and amendments that are made, and he has the privilege of either signing up with it again or getting out. The same goes for the subscriber.
>
> The other contract is between the subscriber and Connecticut Medical Service. When changes are made in the contract, they have to be notified, and they also have the privilege of going on with the thing, with the amendments, or dropping out.

Let's be realistic. Once started on a deal like this, who would, or rather, who *could* drop out. Any quitting would have to be done as a group, because the individual doctor would find it mighty difficult to buck the system. But even in New England someone occasionally gets up on his hind legs and hollers:

> Dr. Hankin. In other words, we have nothing to say about this thing.
>
> Dr. Danaher. Oh, I wouldn't say that.
>
> Dr. Hankin. No, we have nothing to say about it. This is a contract between the participating physician and the group that is running this insurance. I don't see why we even made a committee on it. I don't see why we should even get a report on it, because we have nothing whatever to say about it. We are just told exactly what Dr. Davis told us before. We are told exactly what we can do, told what we can't do, and we can take it or leave it. I don't see why we get the reports on this thing.

In the end, the report of the Professional Policy Committee of the Connecticut Medical Service was accepted, and it is not our purpose to cast aspersion on the report or on the committee. We present the above discussion to show how easily the control of such schemes can pass out of the hands of the House of Delegates. An example of this, in our own state of Indiana, is the continued payment of anesthetist's (and certain other) fees by Blue Cross, as a hospital service, instead of by Blue Shield, as medical ethics would require. This has been protested but to date, as far as we know, nothing has been done about it except the dispensing of a few bottles of a "hog wash" type of excuses.

The original decision in Indiana to support the cash indemnity type of insurance was poured from a very hot crucible. Those favoring it were far more than a majority, yet the proponents of the service type plan were both persistent and vociferous, as well as exceedingly resourceful. It is evident they have not given up, and *if the physicians of Indiana* really want to continue with the indemnity type plan, with doctors in control, they will have to insist on correction of existing usurpations. Eternal vigilance is still the price of liberty.

President's Page

FIVE YEARS OF PROGRESS

THE Indiana Doctor's Plan (Mutual Medical Insurance, Inc.) will be five years old next month. It is, therefore, an appropriate time for the medical profession to review the progress that has been made.

Physicians will remember that the prepayment medical care plan was born out of necessity. It was evident that the people needed some kind of insurance to protect them against the paralyzing effects of large medical bills. No commercial insurance company was willing to assume the risk of writing this type of coverage. The profession was forced to enter the insurance field, for the ominous threat of government control of medicine left it no other choice. The commercial insurance companies later reversed their position and it is encouraging to note that they are now offering policies of this type.

With funds advanced by Indiana physicians, the Blue Shield Plan began operation in September, 1946, its policy being sold as a companion to that of Blue Cross. The growth of Blue Shield membership to 600,000 last month is convincing proof of its successful reception. With the close of the company's books last December 31, 98,965 cases of illness had been processed and a total of $5,132,767 paid out in claims. More than 2,700 physicians shared in the payments during 1950.

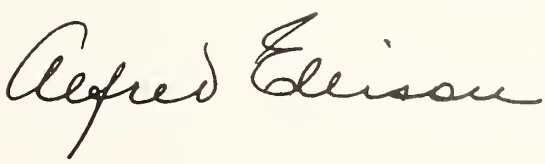
From the very start the problem of spreading the coverage to include persons not eligible for group policies presented itself. But this hurdle was overcome. Health Statement Memberships on an individual basis are now available to persons not otherwise eligible, and through community enrollment drives in eighty-five cities, counties, towns or townships, Blue Cross-Blue Shield benefits have been opened to additional thousands.

On the national level, coverage by voluntary health insurance has grown to the point that seventy-five million or more Americans are now covered. This has taken place in a little more than ten years. This remarkable acceptance by the public of voluntary health insurance is ample evidence that Americans want to do things the American way rather than having compulsion forced upon them. It should be only a question of time when all those who want protection will be covered by Blue Shield or some private insurance company. If the socializers were sincerely honest, they would grant these few short years for this democratic process to accomplish its goal.

When we review the progress of voluntary health insurance in Indiana and the nation, we may get the impression that the economic hazards of sickness are approaching a solution. But the road is long. We dare not be content until a much larger percentage of the population is covered, and until more complete types of coverage are available.

Physicians should never lose sight of the fact that The Doctor's Plan was developed for the public's benefit, not the profession's. Blue Shield has a definite mission, that of making good medical care available at a price within reach of the public. This fact should be uppermost in the minds of doctors.

Blue Shield is being sold to the public as "The Doctor's Plan." Accordingly, the public looks to the profession for results. It behooves every doctor to provide certificate holders with first-class medical care and at a reasonable cost. The people are giving us our chance. Let us follow through and stay free.



Medical Panorama by the Associate Editor

Crum-Bums

Under the above title an editorial appeared in the *Bulletin of the St. Louis Medical Society*, March 30, 1951, which calls attention to "this horrible and revolting development in our modern society," and points out that the physician bears a responsibility to protest against it since he "knows, better than anyone, the mental and physical agony that the addict endures."

The daily press is reporting with increasing frequency, the incidence of narcotic addiction among mere children. To find a name for a character so contemptible that he would peddle dope to kids we must turn to the lexicon of the kids. To them, the lowest form of human life is a "crum-bum."

* * * * *

We quote a headline from a recent newspaper story: "Couple Gets Five Years for Dope Peddling." *Five years!* And they may be free in two, or two and a half, or three years. Free to go back to where they cached the $270,000 they made in six months selling heroin. What crum-bum—or for that matter, a higher order of bum—would not be willing to spend three or even five years in the pokey for that kind of money? The same edition stated that Al Capone's brother faced sixteen years for tax evasion; a writer of rubber checks was sentenced to six years in another story in the same edition. But for a couple who had murdered the souls and minds and futures of kids; who had helped rob them of the opportunity to grow into healthy, happy, ambitious citizens of a community where they could walk proudly with their fellows—five years.

This is in no sense an indictment of the judge who pronounced sentence, for—again we quote—this was "the maximum time the court could impose." If five years constitute the maximum time that a judge is permitted to put away these termites of our social structure, then it is high time that the lawmakers re-examine relative values. If spies, saboteurs, and other traitors to our country can be given life sentences, then those who would sabotage the children upon whom the nation's future depends should be given life sentences. If a murderer can be given the electric chair, then those who would create thieves, murderers, and prostitutes deserve no less. Something drastic should be done to protect these kids!

Whether drastic punishment alone would accomplish the main purpose in view is not certain, but it should help our law-enforcing officers if experienced dope-peddlers were removed permanently from the scene. It seems to us that some dramatic form of education along this line to enable our children to defend themselves against crum-bums would be the very best first line of defense, which in turn should be backed up by the artillery of permanent incarceration of said crum-bums, when apprehended.

Muddled Morality

The April, 1951, issue of the *Westchester Medical Bulletin* (White Plains, N. Y.) contains an editorial on a nonmedical matter too good to omit passing it on to our readers. While "nonmedical," the issue concerns doctors as much as anyone,—and perhaps more so, since we are in the front line of a battle to preserve the decencies and integrity of our profession against the onslaught of those who are not always guileless in their methods. Just read this and you will see what we mean:

The current scene offers some dismal examples of human misconduct. The distorted perspective and warped senses of value typified are comparable to what one would expect from some of the more fantastic characters of Lewis Carroll's "Alice in Wonderland."

In company with millions of others we are troubled and baffled by the recent revelations of major sports scandals, this time involving collegiate basketball and bribery of players for game fixing. The subject has been thoroughly publicized by press and radio, and drastic action and investigation appear to be under way. One university whose players were admittedly involved in bribery has discontinued all athletics except intramural programs. Unquestionably great harm has been done to amateur sports programs at the collegiate level, and all lovers of athletics and youth will decry and regret the tragedy.

But what of the major disease, of which these occurrences are but warning symptoms? Without condoning the actions of the guilty players in any way, we would ask what of the examples of their elders, where the stakes are higher, but the basic principles of conduct and integrity pretty much the same?

Shift the scene now from Madison Square Garden and collegiate basketball to Washington, national politics and high governmental circles and what do we find? According to press reports a "mutual aid," back scratching or political pressure and reward pattern of determining which Reconstruction Finance Corporation Loans to grant with your and my money has been well established. In our naive code the principle is the same, whether cash changes hands in return for favors as with the basketball players at Madison Square Garden and the gambling syndicate, or the payoff is with mink coats or extended expense paid family vacations at swank Miami Beach hotels. Whether legally the latter is bribery or just good politics until you get caught we would not know. What we do know is that in both there is involved moral dishonesty and betrayal of trust, and that the basketball players are mere pikers in comparison with those in high places and the patterns set by them. Somehow, as the curtain is drawn across the scene of the Senate investigation of the R.F.C. as increasingly embarrassing indications of involvement by some of our national leaders and officials is encountered, our sympathies are with the young basketball players. After all betting on basketball games is not compulsory, but paying your Federal taxes is. Are the youngsters guilty of any worse crime than emulating their elders?

As Cicero said to the Roman Senate over 2000 years ago, "O Tempora! O Mores!"

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

THE FAMILY DOCTOR

A trend toward general practice as distinguished from specialization—outlined to the American Medical Association's Atlantic City convention by Dr. Lester D. Bibler, of Indianapolis—can become one of the profession's most potent weapons against government interference. As one of the organizers of the Indiana division of the American Academy of General Practice, Dr. Bibler has recognized "a reaction against overspecialization" and is in a position to understand the growing need for adequate medical services in rural areas and smaller communities.

One factor encouraging specialization has been the disposition of hospitals to favor specialists in staff appointments. To counteract this, the AMA is fostering a movement to encourage the appointment of a larger number of general practitioners to hospital staffs. Running through the Atlantic City meeting was a significant emphasis upon the need for and the service of the family doctor.

There was reassurance for the public in the address of Dr. John W. Cline, of San Francisco, the AMA's new president, who urged all physicians to rededicate themselves to the profession's traditional aim of serving people, rather than making money. In the spirit of this principle, he supported Dr. Bibler's views by pledging a wider distribution of doctors, especially to communities needing medical facilities. More young people are studying medicine than ever before, Dr. Cline pointed out, and before the present decade ends there will be 30% more physicians than in 1950. Thus, unshackled by governmental paternalism, American medicine is redoubling its efforts to its high responsibility to humanity. — *Indianapolis News.*

ANSWERS TO SOCIALIZED MEDICINE

Dr. Elmer L. Henderson, outgoing president of the American Medical Association, believes the "threat of socialized medicine is now dispelled, at least temporarily." If that is true, the AMA deserves the lion's share of the credit, both for its anti-socialization campaign and for its work in improving the standards of medical care.

Dr. Henderson is wise, however, in qualifying his optimistic view with the phrase "at least temporarily." Socializers are masters of the strategic withdrawal. They don't give up. They just retreat to fight another day.

In order to bring semi-permanent defeat to those who would force state medicine on America the voters must trounce them decisively at the polls. Meanwhile, the AMA and similar groups must strive untiringly to prove that voluntary methods can solve the nation's medical care problems.

Aid to medical education, promotion of voluntary health insurance, steps to assure an adequate supply of doctors, establishment of grievance committees, encouragement of 24-hour community medical service and efforts to solve medical care problems in rural areas are among the AMA's undertakings in meeting the challenge of the socializers.

American medicine has achieved its present high position by operating within a framework of individual freedom. There are admitted defects in voluntary medical care. But they can be, and are being, corrected without resort to statist compulsion.

The AMA has been a great public benefactor in its 104-year fight for better medical standards. And it has been a great public benefactor in its spirited fight against the socializers who would bring medicine under the stiffling influence of political control. May it keep up the good work.— *Indianapolis Star.*

GENERAL PRACTICE AND THE HOSPITAL

Lester D. Bibler, M.D.*

INDIANAPOLIS

IN THE past five or six years there has been persistent study of the status of the general practitioner and his role on the hospital staff. From the detailed study and effort, conducted not only by general practitioners, but also by hospital officials, the specialty advisory boards, the American Medical Association and others, three principles have crystallized. These are:

ONE, any physician who is qualified to practice medicine, who is licensed and is reputable, deserves a hospital staff appointment.

TWO, a doctor should be allowed to perform in the hospital any procedures he is qualified to perform, as determined by the professional colleagues of the hospital, not on the basis of certification or special society membership, and

THREE, the hospitals have a responsibility to make available facilities and opportunities for graduate self-training within the hospitals, so that modern standards may be advanced by general practitioners, as well as by specialists.

These principles are to be found again and again in the articles and talks devoted to the subject of the G.P. and the hospital.

What is being done to apply these principles to practice? A great deal has been done and is being done, and we hope more will continue to be done to implement these principles.

To return to the first principle, that every qualified doctor should have a staff appointment. No hospital wishes to change its department standards to include the general practitioner since there seems to be danger that its residency qualifications might be impaired. This is a preposterous situation, so the answer to the problem of integrating the general clinician into the hospital staff is the general practice department or section. Many hospitals have found already that such a section provides properly for general practitioner appointments without radical change of staff organization. Through it the general practitioner has a voice in staff government.

In 1946 the House of Delegates of the American Medical Association adopted a resolution encouraging hospitals to establish general practitioner services. "Such a general practice section," the resolution read, "shall not *per se* prevent approval of a hospital for the training of interns and for residencies."

Concerning the second principle, that a doctor should be permitted to do what he is qualified to do, rather than to impose arbitrary limitations, I think that it is very difficult to put forth an argument to deny a man the right to perform what he is qualified to do. If it means letting him do those procedures in the hospital, then he must be permitted to do them there. If he is frustrated in his attempts to give his patients the best care, the doctor will either lapse into unambitious lethargy, or he may—and you know of instances—perform those procedures he knows in irregular institutions and attempt to perform others he's not yet skilled in, without proper supervision and guidance which he can get only in an accepted hospital.

The hospital is the place for all but the simplest of surgical procedures. It is there the general practitioner must be allowed to perform what he is skilled to do and it is there that he should learn those procedures he wants to learn under skilled supervision.

This brings us to the third principle, that of providing the general practitioner the opportunity to continue his postgraduate self education in the hospital. This means not only providing opportunities for present general practitioners to find the answers to their scientific question, but also providing training for the young doctors who will become the general practitioners of tomorrow, through association under G.P.'s in the teaching hospital.

No hospital wishes to lower the standards of the care available to the community. Therefore, it is to the hospital's advantage to offer a continuous educational program for the general practitioner, so that he is kept constantly abreast of new developments.

The general practitioner's place in the hospital postgraduate education program is not just as a receiver of knowledge. He is not only a voluntary student, but a promising teacher as well. The general practitioner has already been integrated into the teaching staff of some medical schools to bring the student the G.P. slant on medical practice, and the general practitioner has also been invited to participate in teaching in many hospitals. The members of the general practice department who have teaching ability should be encouraged to participate in departmental meetings and in the teaching activities of the hospital staff. The value of having the general practitioner on the teaching staff of a hospital which offers a general practice residency is recognized, but the G.P. is also a valuable man on the teaching staff of any hospital. He is well fitted by his

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wide scope of medical activities to guide a house staff in the subjects of medicine as an art, in medical economics and medical ethics, and community and industrial health facilities. He will be able to give the intern an idea of what general practice is like, something which interns, as well as medical students, lack to a great degree. Both groups work and study in an atmosphere pervaded by the promise of specialization, so that it is no wonder that a young doctor in such an environment thinks more often of going into a specialty than he does of entering general practice.

If the young men who are needed to go into small town practice are to get an inkling of what general practice is like, they must not only be shown the medical school's interest in training doctors for small town general practice, but should also be exposed to general practice and general practitioners during their internship and residency in the hospital.

I am happy to say that a great deal of promising work is being done now. It is gratifying to see some of the medical schools stressing general practice in their schools and setting up general practice residencies in their university hospitals. Other general hospitals are organizing general practice departments, setting up general practice residencies, and are exploring the field of continuing postgraduate education for general practitioners. The American Academy of General Practice has shown its constructive value, as evidenced in part by its "Manual on the Establishment and Operation of General Practice Departments in Hospitals." Medical societies and hospital groups have held symposia to discuss the integration of the general practitioner into the hospital staff. And the Section on General Practice of the Indiana State Medical Association has served as a valuable example of the general practitioner's place in medical organization.

I have not before mentioned the problem of the hospital standardization program. It is as yet unsettled. But I will close with the hope—no, more than a hope—sincere expectation that when it is decided what body shall operate the hospital standardization program, the general practitioner will be justly represented on it, and that body will affirm the three principles:

THAT every reputable physician should have a hospital appointment.

THAT every staff physician be entitled to perform in the hospital those procedures in which he has demonstrated his proficiency, and

THAT the hospital should provide the opportunity for every physician, general practitioner and specialist, to perfect himself in his art.

A.M.A. GIVES ITS BLESSING TO HOSPITAL ACCREDITATION COMMISSION

Homer G. Hamer, M.D.*

INDIANAPOLIS

THE American Medical Association, through its House of Delegates, gave approval at the annual session in Atlantic City in June to a four-organization commission for handling the accreditation of hospitals, beginning January 1, 1952. In addition to the American Medical Association, the organizations are the American Hospital Association, the American College of Surgeons and the American College of Physicians.

The delegates, however, were not entirely satisfied with the number of representatives the American Medical Association would have on the joint commission, as worked out by the Board of Trustees. As tentatively agreed upon by conferees of the four organizations, meeting frequently over a period of nearly a year, the American Medical Association and the American Hospital Association would each have six, and the American College of Surgeons and the American College of Physicians would have three each, making a commission of eighteen members. The delegates recommended that the apportionment be eight from the American Medical Association and four from the American Hospital Association, with no change in the number from the two other organizations. New negotiations to this end will be started. The American Hospital Association meets in September, and if it approves the joint commission, the agency will take over hospital standardization now being handled exclusively by the American College of Surgeons. The other three parent organizations have already taken favorable action.

The Indiana delegates introduced a resolution asking that an "adequate number" of American

*Delegate from Indiana to the House of Delegates, American Medical Association.

Medical Association representatives on the commission be general practitioners. The Reference Committee concurred and recommended that family doctors be included.

REFERENCE COMMITTEE'S RECOMMENDATION

The portion of the Reference Committee's report dealing with the joint commission follows:

"We believe that the negotiating committee of the Board of Trustees has performed a splendid service in gaining an increase in voting power for Doctors of Medicine on the commission gradually from the original ratio of three out of twenty-four, to twelve to eighteen, and for the American Medical Association to six to eighteen. A large number of members in their discussion before the Reference Committee expressed a desire for an even greater proportion in the voting power of the American Medical Association on the commission. We have learned nothing that either the negotiating committee or the Board of Trustees themselves did not wish the same. Indeed, we believe there is a possibility that they did desire it, as shown by the increasing augmentation in this respect from the original proposal to the present one. Therefore, we believe that this House of Delegates should further support the Board of Trustees by recommending that they rearrange slightly the voting power in the commission to:

Three representatives of the American College of Surgeons

Three representatives of the American College of Physicians

Four representatives of the American Hospital Association and eight representatives of the American Medical Association.

"By such an arrangement, an evolutionary process, together with our belief in the astuteness and continued diligence of the Board of Trustees, we believe that we can assure those with opposing resolutions and testimony, that the best interests of all divisions of the medical profession will be amply protected.

"Your committee wishes to call to the attention of the Board of Trustees the desirability of expressions repeatedly made in discussions before them, that general practitioners be represented on the voting body for the American Medical Association, and that an Advisory Committee be formed consisting of representatives from all Scientific Sections of the American Medical Association. To implement these, we recommend that the House of Delegates request that the Board of Trustees should institute these suggestions, and that they make permissible for members of the Advisory Committee to observe the deliberations of the Accrediting Commission, a provision which would allow present consultants from all the medical fields when problems concerning them arise.

"This committee wishes to call to the attention of the Board of Trustees the desirability of statements which were also so frequently expressed, that inspections, discussions and accreditation of hospitals by the Commission from the viewpoint of the medical profession aspects of hospital care be carried out only by the medical representatives on the Commission, and that they convey this philosopy to these representatives after the Commission has been formed, to be implemented when and as soon as it could be possible to do so."

1952 AMA DUES SET AT $25

The House set the dues for the coming year at twenty-five dollars, which is to include a subscription to *The Journal of the AMA*. It was agreed that a member must pay one year's delinquent dues before being accepted into membership. The matter of abolishing Fellowship dues was referred to the Board of Trustees, and the Board will report its recommendations to the House at the interim session.

Dates for future A.M.A. sessions were set as follows:

Annual Sessions: Chicago, June 9 to 13, 1952; New York City, June 1 to 5, 1953; San Francisco, June 1954.

Interim Sessions: Los Angeles, December 4 to 7, 1951; Denver, December 2 to 5, 1952; St. Louis, December 1 to 4, 1953; Miami, December 1954.

A digest of the actions of the House follows:

REPORT OF BOARD OF TRUSTEES

Exemption from membership dues. The Board of Trustees has established the following exemptions from the payment of AMA dues. (1) Members who have retired from the practice of medicine, provided they also are excused from payment of dues, in full or in part, by their county and state societies. (2) Members over 70 years of age, regardless of whether or not they are in practice and regardless of local dues exemption. (3) Members for whom the payment of dues constitutes a financial hardship and who also are excused from payment by their county and state societies for the same reason. (4) Interns and residents, not more than five years after graduation from medical school, except that time spent in military service may be excluded in calculating the five-year limit. (5) Members who enter military service prior to July 1 of any year are exempted from one-half of the year's dues and subsequently during service from full dues.

FEDERAL AID TO MEDICAL SCHOOLS FOR CONSTRUCTION ONLY

The House approved the action of the Board in approving Federal Aid to medical schools provided it is made available on the same basis as Hill-Burton funds for hospital construction, and that the money is used only for construction, equipment and renovation of medical schools with no part of the fund to be used for operating expenses or salaries.

STUDENT AMERICAN MEDICAL ASSOCIATION

Approved the establishment of the Student AMA and the seating of two delegates without voting power from this new Association.

AMERICAN MEDICAL EDUCATION FOUNDATION

The House approved the suggestion of the Board of Trustees that individual physicians who wish to make a contribution to this fund may earmark their gift for use of a medical school of their choice.

TWELVE POINT PROGRAM

The House recommended the establishment of a special committee for the purpose of augmenting this program and that said committee be empowered to make statement of policy concerning the program and its implementation.

REPORTS OF COUNCILS OF THE AMA

Reports of the various Councils of the AMA were presented to the house and approved.

RESOLUTIONS INTRODUCED

Income Tax Exemption for Cost of Technical Education. A resolution calling for the amortization of the cost of technical education as a deduction on income tax reports was referred to the Board of Trustees for further study.

Lay Advisory Group to Board of Trustees. The House approved the appointment of a lay advisory group to serve with the Board of Trustees. Representatives from industry, labor, agriculture, education and other lay strata of the population will be included in the group's membership.

Discontinuance of Federal Funds for Postgraduate Education. A resolution calling for the discontinuance of appropriations in the federal budget, for the purpose of assisting in the financing of postgraduate education programs was adopted. It was felt the physicians should shoulder any and all expenses connected with postgraduate education.

Income Tax. It was agreed that further study should be made with regard to requesting the Internal Revenue Department to reverse its 1921 ruling affecting physicians' income tax reporting. The matter is to be reported on at the interim session.

Investigation of Schools, Teachers and Textbooks. The House adopted a resolution urging "a thorough investigation" by Congress of activities aimed at indoctrination of students in grammar school, high school and college with "the insidious and destructive tenants of the welfare state." It also called for a thorough investigation of the entire school system, with special emphasis being placed upon the teachers and authors of textbooks being used in the schools.

Physician Pension Plan. Calling for support of H. B. 3456 which would permit the establishment of a physician pension plan similar to those in industry, the resolution introduced was ordered held for further investigation by the Board of Trustees. While the delegates felt such a plan meritorious and worth working for, they felt that no expression of favor should be made at this time.

Shortage of Physicians. In view of the many criticisms leveled at the medical profession, the House felt that a clear-cut statement of the plans of the AMA for increasing the number of physicians should be made through the public press. This, it was felt, would combat the publicity now being released by other factions accusing the AMA of working for the curtailment of training new physicians.

Abolishment of Fellowships. A resolution calling for the abolishment of AMA Fellowship membership was introduced, and while the Board of Trustees concurred with the House by approving the resolution in principle, it was referred back to the Board of Trustees for further study, with instructions that the Board should bring its recommendation before the House at the interim session.

Past Presidents as Members of the House of Delegates for a Period of Five Years. A resolution calling for the automatic election of past presidents of the AMA to the House of Delegates, with voting power, for a term of five years, was ordered carried over until the interim session.

Voting Membership in the Board of Trustees Granted Presidents and Presidents-elect. Explaining that in industry and commerce, presidents and presidents-elect are granted voting rights on their boards, the House voted to grant voting membership to these AMA officers on the Board of Trustees. Heretofore the president and president-elect were ex-officio members of the Board without right of voting.

Establishment of "Little Hoover Commission" Within the AMA. The House authorized the establishment of a special committee for the purpose of making a study of the standing committees of the House of Delegates and their relation to the Association, this committee to report its findings at the interim session.

Increase of Delegate Representation. A resolution requesting the granting of more than one delegate to states having a membership of one thousand or less was defeated.

Interpretation of Term "Executive Session." The House requested that an interpretation and clarification of the term "Executive Session" as it now appears in the AMA by-laws be made.

Standardization of Accident Insurance Reporting Forms. A resolution calling for the standardization of all insurance reporting forms for use in reporting accidents was not approved due to the difficulty in preparing a form that would be suitable for use in all localities, and for the many forms of accident insurance now in force.

Insurance Forms Prepared by Council on Medical Service. The House approved a resolution calling upon the Council on Medical Service to submit copies of all its approved reporting forms to each state and county medical society.

Committee on Nervous and Mental Diseases. Authority was granted by the House for the establishment of a Committee on Nervous and Mental Diseases.

Code of Ethics. A new statement regarding fee splitting, overcharges, royalties on patents, as being unethical was adopted.

Relationship With Optometrists. A resolution calling for reversal by the House of its action at the San Francisco session approving the ethics of ophthalmologists lecturing to optometrists, was defeated and the previous action of the House was reaffirmed. This permits members of the AMA to lecture to optometrists.

Free Speech in Journal. A resolution calling for space to be provided in *The Journal* for publication of considered discussion by a member was approved.

Practice of Medicine in Hospitals. The House authorized immediate steps taken to acquaint the public, hospital trustees and physicians on the practice of medicine in hospitals.

Physician Supervision of All Curative Workshops. The House approved a resolution calling for a qualified licensed physician to be in supervision of all occupational therapy and all forms of physical therapy in curative workshops.

Unethical Sales Promotion Methods. Attention of the House was called to the use of unethical sales promotion material being used by one of the country's large concerns, pointing out that it attempted to discriminate between various types of medical services and care. The House approved a resolution calling for the Association to contact the advertising agencies of the nation in an attempt to bring about a correlation of advertising programs with practice of modern medicine.

Opposition to Communism, etc. The House approved a resolution calling for a strong statement being made of the opposition of the medical profession to all forms of communism, socialism, fascism, etc.

Training of Foreign Interns. The House approved a resolution calling upon all states to work for approval of the training of foreign interns in the hospitals of the United States. Not only is this an opportunity to teach them good medical practices, but it also offers an excellent opportunity for indoctrinating these students with the principles of democracy.

Multiplicity of Hospital Meetings. The trend toward making hospital staff meetings paramount to medical society meetings was pointed out in a resolution which called attention to the fact that county medical society meetings must always take priority over hospital staff meetings, and that the combining of county society, staff, and pathological meetings should be permitted wherever desirable. This resolution was referred to the Committee on Medical Education and Hospitals with instructions that its findings and recommendations be reported at the interim session.

Medical Preceptorships. A resolution calling for the establishment of preceptorships by all medical schools failed in favor of a report by the reference committee that this matter be left to the judgment of the deans of the various medical schools, the local county and state medical societies, and the Junior American Medical Association.

Supervision of Radiology Departments. A resolution calling for all departments of radiology to be under the supervision of only a member of the Radiological Board, and if a department cannot find a board member or cannot afford one, that it be required to seek the services and advice of a member in an adjoining community, was referred to the Council on Medical Education and Hospitals for further study.

Requirement of 4-Month G. P. Training in All Intern and Residency Programs. This resolution was referred to the Council on Medical Education and Hospitals for further study.

Relationship Between AMA and Voluntary Health Insurance Agencies. A resolution calling for a special study by the Council on Medical Service of the relationship between the AMA and voluntary health insurance companies was laid on the table.

Emergency Medical Call Services. A resolution calling on the specialties to issue statement of approval of their membership, and to request their membership to serve on emergency medical call systems was approved.

Congratulations to Societies Sponsoring Health Insurance Plans. The House approved a resolution of congratulations to all medical societies who are sponsoring voluntary health insurance plans.

Journal Space for Council on Medical Service. Approval was granted by the House to a resolution calling for making space available to the Council on Medical Service for use in reporting its activities for the dissemination of health insurance news.

Public Relations Section. A resolution calling for the establishment of a Public Relations Section in the Sections and Section Work was not approved.

Physicians and Public Relations. The House instructed the Board of Trustees to exert every effort to interest physicians in public relations.

Appreciation to Whitaker and Baxter. For the splendid work in behalf of American Medicine and requesting that their services be used by the Board of Trustees, if necessary, was the subject of a resolution approved by the House.

Approval of Label for Iodized Salt. A resolution calling for the development of a special label by the Council on Foods and Nutrition for use by the salt industry on packages of iodized salt was referred to the Council for study and for reporting its findings at the next session.

FORMATION OF COMMITTEES ON CHRONIC DISEASE

The report on the formation of a National Committee on Chronic Diseases and the recommenda-

tion that similar committees be established at the state and county level were approved.

INDUSTRIAL HEALTH PRINCIPLES BY BOARD OF TRUSTEES

It was recommended that the Industrial Health Principles reported by the Board of Trustees be standardized for use by each of the states.

UMT ACT

It was requested that the Committee on Emergency Medical Service maintain close liaison with the Federal Government, to determine the policy intended to be followed by the government in the new Universal Military Training Act, and the relation it will have to the practice of medicine. The committee is to report its findings as soon as possible to the Board of Trustees.

NATIONAL SECURITY ACT

The House adopted a strong resolution endorsing the National Security Act, and opposing any form of communism, etc., and stating that all civil control must be maintained and returned to the respective civil levels.

SPECIALTY CENTERS IN V. A. HOSPITALS

The House approved the establishment and operation of specialty centers in V. A. hospitals for use of service men who are so severely injured that they cannot return to active service.

RETENTION OF WHITAKER & BAXTER

Upon recommendation of the Board of Trustees approval was given for the retention of the firm of Whitaker & Baxter for another year.

CONTINUATION OF COORDINATING COMMITTEE

The House approved the continuation of the AMA Campaign Coordinating Committee with the same membership for another year. Dr. Elmer L. Henderson agreed to continue as chairman of this committee.

ELECTION OF OFFICERS

The following officers were elected by the House:

President-elect, Louis H. Bauer, M.D., Hempstead, N. Y., who has been serving as chairman of the Board of Trustees.

Vice-president, Oscar B. Hunter, M.D., Washington, D. C.

Secretary, George F. Lull, M.D., re-elected.

Speaker of the House, F. F. Borzell, M.D., Philadelphia, re-elected.

Vice-speaker, James R. Reuling, M.D., Bayside, N. Y., re-elected.

Board of Trustees, Walter B. Martin, M.D., Norfolk, Va., re-elected for another term. David B. Allman, M.D., Atlantic City, was elected to fill the unexpired term of Doctor Bauer.

INDIANA MEMBERS ELECTED TO ASSOCIATE FELLOWSHIPS:

W. D. Asbury, Terre Haute
Charles R. Bird, Indianapolis
Samuel J. Copeland, Indianapolis
W. N. Culmer, Bloomington
M. F. Daubenheyer, Richmond
G. R. Douglas, Valparaiso
W. L. Green, Pekin
Merle D. Gwin, Miami Beach, Florida (formerly of Rensselaer)
John A. Kent, Mulberry
A. R. Logan, Petersburg
J. R. Pearson, Bedford
C. W. Rutherford, Indianapolis
E. M. Shanklin, Hammond
S. J. Young, Kendallville

Indiana medicine was represented in the House of Delegates by Drs. F. S. Crockett of Lafayette, E. S. Jones of Hammond, Cleon A. Nafe of Indianapolis, and the writer, who was chairman of the Reference Committee on Executive Sessions.

Dr. C. H. McCaskey, of Indianapolis, was elected chairman of the Section on Laryngology, Otology and Rhinology. Dr. L. G. Montgomery, of Muncie, was elected vice-chairman of the Section on Pathology and Physiology.

INDIANA PHYSICIANS ON PROGRAM

Nine Indiana physicians presented papers at section meetings. They were Drs. V. K. Stoelting, J. P. Graf, Boynton H. Booth, Alexander T. Ross, George J. Garceau, Eugene Salvati and J. Neill Garber, all of Indianapolis, and Wallace S. Tirman and Harry W. Banker, both of Bluffton.

Scientific exhibits were presented by the Reilly Mycology Laboratory of the Alembert Winthrop Brayton Skin and Cancer Foundation of Indianapolis; Dr. Lall G. Montgomery of Muncie, for the American Society of Clinical Pathologists; and Drs. Tirman, Banker and Charles B. Caylor of Bluffton.

Three of the nineteen sections were chairmanned by Indianapolis doctors. They were Dr. Lester D. Bibler, Section on General Practice; Dr. Robert J. Masters, Section on Ophthalmology, and Dr. John Eric Dalton, Section on Dermatology.

INDIANA PHYSICIANS REGISTERED AT THE MEETING

Abreu, Benedict E., Indianapolis
Allen, Hubert E., Richmond
Arbogast, J. L., Indianapolis
Arbogast, Paul B., Vincennes
Arlook, Theodore D., Elkhart
Armington, Robert L., Anderson
Baum, Harry, Indianapolis
Beeler, Raymond, Indianapolis
Berman, J. K., Indianapolis
Biasini, Ben, South Bend
Bibler, Lester D., Indianapolis
Bishop, Charles A., South Bend
Bolin, Robert S., Elkhart
Bond, George S., Indianapolis
Booth, Boynton H., Indianapolis
Borders, Theodore R., Fort Wayne
Briscoe, Clarence E., New Albany
Butterfield, Robert M., Muncie
Casey, Stanley M., Huntington
Cameron, Don F., Fort Wayne
Cavins, Alexander W., Terre Haute
Caylor, Truman E., Bluffton
Chroniak, Walter, Indianapolis
Conklin, Raymond, Elkhart
Cope, S. E., Huntington
Cortese, Thomas A., Indianapolis
Crandall, L. A., Elkhart

Crimm, Paul D., Evansville
Crockett, F. S., Lafayette
Dalton, John E., Indianapolis
Davidoff, M. A., Ossian
Doenges, James L., Anderson
Durkee, Melvin S., Evansville
Edlavitch, B. M., Fort Wayne
Egan, Sherman L., South Bend
Ellison, Alfred, South Bend
Eviston, J. B., Huntington
Faltin, Ladislaus, South Bend
Fargher, F. M., Michigan City
Fausset, C. Basil, Indianapolis
Franklin, William L., Indianapolis
Frankowski, C. E., Whiting
Frost, John W., Indianapolis
Garber, J. Neill, Indianapolis
Garceau, George J., Indianapolis
Gastineau, Frank M., Indianapolis
George, Charles L., Indianapolis
Gilbert, Ivan, Terre Haute
Green, Carl, Vincennes
Green, George F., South Bend
Grisell, Ted, Indianapolis
Hamer, Homer G., Indianapolis
Hattendorf, A. P., Fort Wayne
Henderson, Francis G., Indianapolis
Heritier, Jules, Columbia City
Hilldrup, Don G., Indianapolis
Hines, Don C., Indianapolis
Hoffman, Arthur F., Fort Wayne
Holland, Philip T., Bloomington
Hollingsworth, A. A., Indianapolis
Hurley, Anson, Muncie
Hurley, John R., Daleville
Irey, Paul R., Plymouth
Iske, Paul G., Indianapolis
Johnston, Robert L., Bluffton
Jones, E. S., Hammond
Kahler, Maurice V., Indianapolis
Kirtley, William R., Indianapolis
Kohlstaedt, Kenneth G., Indianapolis
Kruse, Edward H., Fort Wayne
Lamey, P. T., Anderson
Lybrook, D. E., Young America
Lynch, Otis R., Marengo
McCaskey, Carl H., Indianapolis
McConnell, William, Sunman
McCormick, C. O., Jr., Indianapolis
McDowell, Fletcher, Muncie
McFarland, Corley B., South Bend
McIntyre, J. M., Indianapolis
Mahuron, Boyd L., Muncie
Martin, Hugh, Indianapolis
Masters, Robert J., Indianapolis
Meiser, Robert D., Huntington
Michaelis, Stephen C., Fort Wayne
Mino, Victor H., Evansville
Mishkin, Irving, Elkhart
Montgomery, Lall G., Muncie
Moss, Mavor J., Yorktown
Nafe, Cleon A., Indianapolis
Nason, R. A., Garrett
Newcomb, W. K., Royal Center
Norman, Olin B., Indianapolis
Orr, W. Robert, Mishawaka
O'Rourke, Carroll, Fort Wayne
Otten, Ralph, Darlington
Owens, Thomas R., Muncie
Pace, Jerome V., New Albany
Peck, Franklin B., Indianapolis
Pfuetze, Max E., Logansport
Ragsdale, H. C., Bedford
Reed, Roger, Anderson
Rice, Raymond M., Indianapolis
Ritteman, G. W., Columbus
Rosenwasser, Jacob, Mishawaka
Ross, Alexander T., Indianapolis
Row, George S., Osgood
Rubens, Eli, South Bend
Ruddell, Karl, Indianapolis
Schlaegel, T. F., Jr., Indianapolis
Schiller, Herbert A., South Bend
Schulhof, Maurice G., Muncie
Schulze, William C., Vincennes
Sensenich, R. L., South Bend
Siekierski, J. M., Griffith
Shumacker, Harris B., Jr., Indianapolis
Slaughter, John S., Evansville
Smith, M. Hunter, Goodland
Snively, W. D., Jr., Evansville
Souter, Martha, Indianapolis
Stafford, J. C., Plainfield
Stangle, J. W., Plainfield
Stine, Marshall, Bremen
Stoelting, V. K., Indianapolis
Stout, Richard B., Elkhart
Stygall, James H., Indianapolis
Sullivan, John M., Terre Haute
Thompson, John M., South Bend
Thompson, John V., Indianapolis
Tirman, Wallace S., Bluffton
Warvel, J. H., Indianapolis
Weigand, Clayton G., Indianapolis
Weiss, H. G., Evansville
Wertenberger, Morris D., Richmond
Whitlock, Merle E., Mishawaka
Wilson, Fred M., Indianapolis

THE HEALTH OF OUR PIONEER ANCESTORS*

W. D. Gatch, M.D.

INDIANAPOLIS

WE HAVE no vital statistics on the midwestern pioneers. We derive what we know about the state of their health partly from what our grandparents told us, partly from contemporary writings, and partly by deduction from the known state of medicine and sanitation in pioneer times. The knowledge so obtained, though incomplete, is considerable and important.

The pioneer health period did not end with the settlement of the country. It extended in reality to the time when, because of the progress of medical science, control of the chief diseases became possible. This was no earlier than the first decade of the present century. Thus Osler in his textbook of medicine published in 1892 noted but three specific remedies—mercury for syphilis, iron for anemia, and quinine for malaria!

The health of our pioneer ancestors was bad. Their bodily afflictions affected their characters and religious beliefs and therefore the history of their communities. What little professional medical care they had was of doubtful value. (George Washington's physicians bled him to death!) Medical science worthy of the name did not exist anywhere in those days. No anesthetic made painless the reduction of a fracture or the pulling of a tooth. The only pain-killing drugs the pioneers had were opium and whiskey. The hypodermic syringe is the most important instrument ever possessed by the physician. It was but little used till after the Civil War. A patient who could not take medicine by mouth had to endure his pain.

Child bed fever, appendicitis, strangulated hernia, urinary obstruction, diabetes, pernicious anemia, severely infected wounds and a great number of other ailments now easily curable, were usually fatal. Rodent ulcer caused terrible mutilation of the face. Epileptic convulsions could not be prevented.

Dentistry was crude. Toothache was a common and dreadful affliction. Teeth were torn from their

*Presented at a meeting of the Society of Indiana Pioneers, at Indianapolis, December 9, 1950.



The last hours of a morphinist. A picture published about 1870. Every hypodermic injection caused an abscess before the use of aseptic technique.

sockets with a cant hook extractor. False teeth were instruments of torture, worn for looks and not for chewing. They were unknown in the back woods. Washington had a set made of ivory and held in place with springs. It was useless even for show, because his mouth was stuffed with cotton to push forward his lips when Stuart painted his portrait.

The pioneer who had poor eyesight had to put up with it. Eye-glasses were defective and must have been but little used before the country was fairly well settled.

The Indian was less dangerous than the automobile. This kills more people every six months than the Indian killed in 300 years. Even trivial wounds, however, were very dangerous because their infection could not be prevented.

Food was plentiful and cheap, but the diet in winter was monotonous and lacked vitamins. The settlers, however, did know how to prevent scurvy. The energy which felled the forests, built the canals and early railroads, and fought the Civil War came from pickled pork, nick-named sowbelly. This was also the chief article of commerce carried south in Ohio River flatboats.

A total lack of sanitation was the most shocking feature of pioneer life. This is an unpleasant fact, but to ignore it is foolish. No baths except in summer in the Old Swimming Hole; few handkerchiefs; spitting everywhere; privies without pits; flies, mosquitoes and bed bugs. The flies persisted till very recent times. They buzz loudly in the pages of *The Gentleman from Indiana*, published in 1899. Pints of them were caught in traps. They were shooed from the tables of the well-to-do with big fans or tufts of paper strips on the ends of poles. Mosquitoes were numerous everywhere till the land was brought under cultivation and drained. Bed bugs could not be ousted from a log cabin without burning it down. They infested taverns and steamboats.

The death rate of infants and children was very high, and the average length of life before 1850 was probably not over 40 years. We must not conclude from this, however, that many of our ancestors failed to reach old age. The great increase in the average length of life, which has occurred in the last few decades, is due in great part to the conquest of diseases of childhood. This conquest, unfortunately, has increased the frequency of cancer and vascular disease. For the children we save from tuberculosis and diarrhea live to die of cancer, or heart disease, or apoplexy. A man aged 40 in 1820 had almost as good a chance of living to be 80 as a man aged 40 has today.

The chief diseases of pioneer Indiana were malaria, typhoid fever, tuberculosis, dysentery, and milk sickness. Epidemics of Asiatic Cholera are said to have occurred in Indiana before the Civil War, but I doubt that proof of this exists.

Malaria was endemic in all parts of Indiana. It was probably the most common cause of illness and a frequent cause of death during the first quarter of the Nineteenth Century. The great grandparents of a man I know died about 1810 in southern Indiana of a very severe form of malaria called black water fever. Every household had a solution of quinine in whiskey on its mantlepiece. The disease was thought to be due to noxious vapors emanating from swampy grounds. This is one reason why the uplands of southern Indiana were settled before the more fertile lowlands. The incidence of malaria decreased as the land was brought under cultivation and drained.

Typhoid fever was extremely common and so remained till the second decade of the present century. This is no cause for wonder when we consider the bad sanitary conditions I have mentioned. The drinking water in towns was unbelievably bad. Thus the people of Cincinnati drank raw water from the Ohio River, the mud from which would settle to the bottom of drinking glasses. This was true up until about the end of the last century when a filtration plant was installed. The victims of typhoid fever were starved and given but little water. This made the disease much more dangerous to life.

Tuberculosis was common. It not infrequently destroyed entire families. Crowded living quarters, poor ventilation, and spitting spread the disease. No one thought of isolating the sufferers.

Epidemics of dysentery were frequent. Our forefathers called it the flux and one form of it the bloody flux. It was often rapidly fatal. The unsanitary conditions which favored the spread of typhoid favored that of dysentery. These diseases were the chief enemies of armies.

If we can believe contemporary writers, milk sickness was one of the chief causes of death among pioneers. Other names for it were the "puking sickness," the "staggers," the "trembles," and the "slows." In Dubois County in Indiana half the deaths occurring in 1815 were said to have been caused by this disease. In 1819 it was common around Vincennes. We know now that it was caused by a poison found in the leaves of the white snake root. When these were eaten by the cow the poison was excreted in her milk, which in turn poisoned humans. The symptoms of the dis-

ease were fever, muscular weakness, tremors, vomiting, collapse and death.

Nancy Hanks is believed by some to have died of milk sickness at the youthful age of 35 on the seventh day after she had taken sick. The prevalence of this disease may have caused the Lincoln family to move to Illinois. I have already mentioned that the highlands of southern Indiana were settled before the lowlands. Milk sickness was most likely to occur in the lowlands because the white snake root grows only in wet soil. The disease has now almost entirely disappeared.

The idea that modern life has made mental derangement more frequent is doubtful. Our forefathers were beset by loneliness, disease, privation and fears—troubles as cogent as any which afflict us. Suicide among them was common. A primitive society manages somehow to care for its insane without putting them into asylums.

The aged of old times were better off than are the aged of today. Their children felt duty bound to care for them. They still had a place in family and community life.

All European travelers in America during the early part of the 19th Century comment on the total lack of amusements, on the hard labor which the people performed for at least 12 hours a day, and on the tremendous influence of religion. Mrs. Trollope noted that an evangelist in Ohio in 1829 was as much sought after as the eldest son of a Duke in England. Religious exercises gave the people their sole emotional outlet. They would travel for miles to camp meetings, where they could spend days or even weeks and develop all sorts of hysterical symptoms. To people faced all their lives by the fear of death in its most grisly forms, religion was a very present help.

The deathbed scene was frightful. No hypodermic injections prevented the pangs of dissolution. The hour of death, therefore, filled our ancestors with terror. They crowded around the death bed weeping and singing special hymns for the comfort of the dying.

"Come angel band,
Come and around me stand.
O bear me away on your snowy wings,
To my immortal home."

I remember as a child hearing aged people describe deathbed scenes at which they had been thrilled by the rustle of angel wings.

The law of the survival of the fittest was in full force among the pioneers. I have already mentioned that many of them reached an extreme old age. To do this it is necessary that the individual have a high resistance to infection and to cardiovascular disease. The lack of sanitation and of medical care, worthy of the name, had at least the merit of producing people with these characteristics.

A LESSON IN SOCIALISM

As a teacher in the public schools, I find that the socialist-communist idea of taking "from each according to his ability," and giving "to each according to his need" is now generally accepted without question by most of our pupils. In an effort to explain the fallacy in this theory, I sometimes try this approach with my pupils:

When one of the brighter or harder-working pupils makes a grade of 95 on a test, I suggest that I take away 20 points and give them to a student who has made only 55 points on his test. Thus each would contribute according to his ability and—since both would have a passing mark—each would receive according to his need. After I have juggled the grades of all the other pupils in this fashion, the result is usually a "common ownership" grade between 75 and 80—the minimum needed for passing, or for survival. Then I speculate with the pupils as to the probable results if I actually used the socialistic theory for grading papers.

First, the highly productive pupils—and they are always a minority in school as well as in life—would soon lose all incentive for producing. Why strive to make a high grade if part of it is taken from you by "authority" and given to someone else?

Second, the less productive pupils—a majority in school as elsewhere—would, for a time, be relieved of the necessity to study or to produce. This socialist-communist system would continue until the high producers had sunk—or had been driven down—to the level of the low producers. At that point, in order for anyone to survive, the "authority" would have no alternative but to begin a system of compulsory labor and punishments against even the low producers. They, of course, would then complain bitterly, but without understanding.

Finally I return the discussion to the ideas of freedom and enterprise—the market economy—where each person has freedom of choice, and is responsible for his own decisions and welfare.

Gratifyingly enough, most of my pupils then understand what I mean when I explain that socialism—even in a democracy—will eventually result in the living-death for all except the "authorities" and a few of their favorite lackeys.

THOMAS J. SHELLEY,
Teacher of Economics and History, Yonkers High School, Yonkers 2, New York

1951 INSTRUCTIONAL COURSES

In the September and October issues of THE JOURNAL, this page will contain the schedule of courses and the reservation blank for the Instructional Courses of the 1951 session.

The tickets for each course will be reserved in order as your reservations are received. Be ready to make your selection when your JOURNAL arrives in September.

As usual, each class will be limited to thirty. The informal qualities possible in so small a group add much to the value of the class. There will be no "papers." Each instructor will be one with primary interest and knowledge in the subject he will present. You may count on an opportunity to have your questions discussed and answered toward the end of the hour.

Be prepared to spend Monday, October 29, in school again. The schedule will be on this page in the September JOURNAL. First come, first served. Only 30 in each class.

COMMITTEE ON INSTRUCTIONAL COURSES:

Gordon W. Batman, M.D., Indianapolis
Russell A. Sage, M.D., Indianapolis } Co-chairmen

John D. Van Nuys, M.D., Indianapolis

J. Lawrence Sims, M.D., Indianapolis

E. Paul Tischer, M.D., Indianapolis

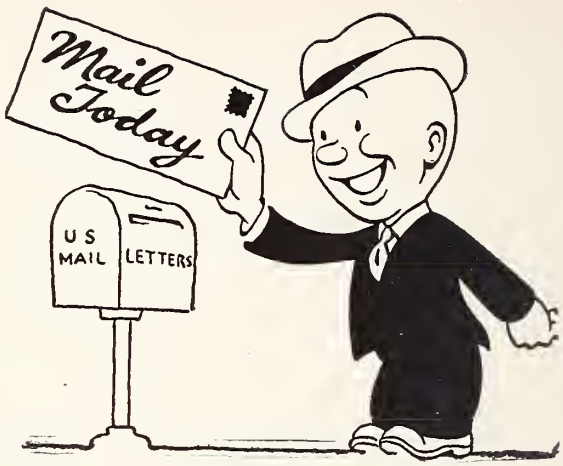
Floyd T. Romberger, Jr., M.D., Indianapolis

Seth W. Ellis, M.D., Anderson

Time to Make Hotel Reservation

Going to attend the annual session of the Indiana State Medical Association in Indianapolis on Monday, Tuesday and Wednesday, October 29, 30 and 31, 1951?

It's time to make your hotel reservation.



Hotels	Rates (Start) Single	Double
Antlers, 750 N. Meridian	$4.25	$6.25
Barnes, 233 McCrea Place	$2.50	$3.50
Barton, 505 N. Delaware	$2.75	$4.00
Claypool, 14 N. Illinois	$4.60	$6.30
Harrison, 51 N. Capitol	$3.75	$5.75
Jones, 248 S. Illinois	$2.50	$4.50
Lincoln, 117 W. Washington	$4.00	$6.25
Linden, 311 N. Illinois	$2.00	$3.50
Marott, 2625 N. Meridian	$6.00	$8.00
New English, 6 W. Michigan	$2.00	$3.00
Pennsylvania, 947 N. Penn	$3.50	$5.00
Severin, 201 S. Illinois	$4.50	$6.50
Sheffield, 958 N. Pennsylvania	$3.50	$6.00
Spink Arms, 410 N. Meridian	$3.50	$6.00
Warren, 123 S. Illinois	$4.00	$6.00
Washington, 34 E. Washington	$3.50	$5.00

TIME OF EVENTS

MONDAY, OCTOBER 29

Instructional Courses, Stag Party, Golf, Trapshoot, Party for Women.

TUESDAY, OCTOBER 30

Scientific Program, entertainment at night for doctors and wives, Murat Theater.

WEDNESDAY, OCTOBER 31

Scientific Program, reception for Fifty Year Club, annual dinner and dance.

FORM FOR MAKING HOTEL RESERVATION

(Clip out this form, fill it out, and mail to hotel of your choice)

You are requested to reserve the following accommodations during the annual meeting of the Indiana State Medical Association, October 29, 30 and 31, 1951, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price.....

☐ Twin Bed Room with bath ☐ Suite

Arrival date .....A. M. .....P. M.

Departure date .....A. M. .....P. M.

Name .....

Address .....

.....

.....

News Notes

POSTGRADUATE CANCER COURSE

Indiana University Medical Center will conduct a well-organized postgraduate course in malignant diseases for two days on September 26 and 27. Early detection and management of neoplastic diseases will be stressed in demonstrations, ward walks, clinics and conferences. Attendance will be limited. Reservations, which are now being made on a first-come-first-served basis, will close on September 5. Fee for the course is $30.00. A dinner meeting at the Indianapolis Athletic Club is scheduled for the night session of the first day, and will feature Dr. Stanley P. Reimann of Philadelphia; subject: "The General Care of the Cancer Patient."

COURSES IN EXFOLIATIVE CYTOLOGY CORNELL UNIVERSITY MEDICAL COLLEGE

September 17—December 14, 1951.

March 3—May 29, 1952.

These two courses will be open to a limited number of physicians and technicians. They will cover the cytology of the female genital, gastrointestinal, respiratory, and urinary tracts, as well as exudates. Instruction in laboratory procedures related to cytology will also be given. Tuition for each course is $300.00.

Instruction will be given by Dr. George N. Papanicolaou, Dr. John F. Seybolt and their associates. For further information and application blanks, write to: Dr. John F. Seybolt, Department of Anatomy, Cornell University Medical College, 1300 York Avenue, New York 21, N. Y.

USPHS HOSPITALS

Hospitals operated by the Public Health Service under the name "U. S. Marine Hospitals" were redesignated as United States Public Health Service Hospitals beginning July 1, 1951, Dr. Leonard A. Scheele, Surgeon General of the Public Health Service announced.

This will provide a uniform designation for the 21 hospitals now operated by the Service, Dr. Scheele said, and simplify administrative procedures in their administration.

In a letter to maritime unions and other interested groups Doctor Scheele pointed out that during the years since 1798, when President John Adams approved legislation creating a medical care program for merchant seamen, Congress has increased the number of groups entitled to treatment at the hospitals and the old designation was no longer descriptive of the functions performed.

INTERNATIONAL COLLEGE OF SURGEONS

The Sixteenth Annual Assembly of the United States Chapter of the International College of Surgeons will be held in Chicago September 10, 11, 12 and 13, 1951, with headquarters at the Palmer House. An excellent program has been arranged. Prominent surgeons from the United States and other countries will participate. Scientific sessions will be held by all specialty sections of the United States Chapter. All physicians are invited to attend the scientific sessions and the exhibits.

Hotel reservations may be arranged by writing to the Housing Division, Chicago Convention Bureau, 33 North LaSalle Street, Chicago 2.

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

Papers will be presented by 24 outstanding doctors of medicine throughout the United States at the 86th Annual Session of the Michigan State Medical Society, J. Duane Miller, M.D., Grand Rapids, Chairman of the meeting, announced.

The annual meeting will be held in Grand Rapids September 26, 27, and 28 at the Pantlind Hotel and Civic Auditorium. Doctor Miller issued a cordial invitation to all doctors of medicine in neighboring states to attend the scientific meeting in Grand Rapids.

Veterans' Administration has announced the appointment of new managers for two of its hospitals, one of which is in the final phase of construction.

The new managers are **Dr. Edward S. Post**, for the hospital in Sheridan, Wyoming; and **Dr. Morris C. Thomas**, for the hospital soon to be completed in Madison, Wisconsin.

Doctor Post came to V-A in 1934 and since then has served in a number of its hospitals. In 1947 he was appointed chief of the neuropsychiatric section of the former V-A branch office in Chicago, Illinois. The following year he was named manager of the Fort Custer V-A hospital. A graduate of Indiana University, Doctor Post completed his internship in 1932 at South Bend. He is a Navy veteran of World War I.

Doctor Thomas, manager-to-be at the Madison V-A hospital, presently is manager of the Waukesha, Wisconsin, V-A hospital. He came to V-A in 1946 after six years' service in the Army. His first appointment at V-A was as chief of the tuberculosis unit at the V-A Center in Dayton, Ohio. In 1948 he became manager of the Waukesha hospital. He received his M.D. degree from the University of Indiana in 1930 and interned at the Methodist Hospital in Indianapolis.

At the seventeenth annual meeting of the American College of Chest Physicians, in Atlantic City in June, **Dr. James H. Stygall**, of Indianapolis, was re-elected chairman of the Board of Regents. **Dr. Jerome V. Pace**, of New Albany, is governor of the college for Indiana.

Dr. Robert Abel has opened an office for the practice of medicine in Wakarusa. He is a graduate of Indiana University and interned at Indianapolis General Hospital.

Dr. Harold H. Chappell has opened an office for the practice of medicine in Oakland City. A June 1950 graduate of Indiana University, Doctor Chappell has just completed his internship at Sewickley Valley Hospital in Pittsburgh, Pennsylvania.

Dr. Wilson Dalton has taken over the practice of **Dr. W. M. Wiley** at Shelbyville. Doctor Wiley has taken a surgical residency at the Detroit Receiving Hospital. Doctor Dalton is a graduate of Indiana University School of Medicine and a veteran of World War II.

A 1950 graduate of Indiana University School of Medicine, **Dr. Bill Freeland** has opened an office for the practice of medicine in Batesville. He has recently completed his internship at St. Vincent's Hospital in Indianapolis.

Dr. James B. Warriner has opened an office for the practice of internal medicine at 975 N. Emerson Avenue, in Indianapolis. He is a 1941 graduate of Indiana University School of Medicine, and spent approximately four years in the Army. Following his release from service, he has been chief resident at the Methodist Hospital in Indianapolis.

Following his residency at the Indiana University Medical Center, **Dr. Hunter A. Soper** has entered the Armed Services, and is stationed at San Antonio, Texas.

A 1942 graduate of Indiana University School of Medicine, **Dr. Donald H. McCartney** has become associated in the practice of orthopedics with **Dr. Frank Teague** at 918 Hume Mansur Building, in Indianapolis. Doctor McCartney recently completed a residency in orthopedics at the Indiana University Medical Center.

Upon completion of a residency in medicine at Indianapolis General Hospital, **Dr. Robert J. Marvel** has opened an office at 3311 North Meridian Street, in Indianapolis. He is a 1944 graduate of the University of Nebraska School of Medicine, and spent two years in the Army.

Dr. Ronald H. Hull has been transferred from the U. S. Army Hospital at Fort Eustis, Virginia, to the U. S. Naval Hospital at Portsmouth, Virginia.

Dr. Howard J. Henry, formerly of Knox, has announced the opening of an office for the practice of medicine in Plymouth. Following service in World War II, Doctor Henry practiced in Knox for three years, and was recalled to Army duty last summer, but has recently received his discharge.

Dr. Donald M. Harris, of Gary, has been appointed health and welfare adviser to U. S. High Commissioner of Germany John J. McCloy. Doctor Harris served in Germany during World War II as a U. S. Army medical officer.

Dr. Thomas Hamilton has begun the practice of medicine in Columbia City. He is a graduate of Wayne University School of Medicine, and a veteran of World War II.

Dr. Charles Eugene Jackson has become associated with the Caylor-Nickel Clinic at Bluffton. He is a member of the staff of internal medicine there. He is a 1946 graduate of Indiana University School of Medicine, and interned at the Scott and White Hospital at Temple, Texas. He also took postgraduate work at Tulane University School of Medicine.

Announcement has been made that **Dr. Lewis C. Lohoff** has become associated in practice with **Dr. Noel L. Neifert** at Tell City. Doctor Lohoff is a graduate of the University of Colorado School of Medicine, and has served in the U. S. Navy since graduating.

Dr. Maurice I. Marks has opened an office at 2901 N. Meridian Street in Indianapolis for the private practice of surgery. A 1938 graduate of Emory University, Doctor Marks was a colonel in the Army where he served for approximately four years, following which he was surgical chief at the Billings VA Hospital.

Upon completion of a residency in pediatrics at Indianapolis General Hospital, **Dr. Donald L. Rogers** opened an office on July 1 at 3311 North Meridian Street, in Indianapolis. He is a 1946 graduate of Indiana University School of Medicine, and was a captain in the Army for two years.

Dr. Charles Fisch has opened an office at 3120 North Meridian Street in Indianapolis, after completion of a residency in medicine at Indianapolis General Hospital. He is a 1944 graduate of Indiana University School of Medicine, and was a captain in the Army.

Dr. Charles E. Test has opened an office at 1002 Hume Mansur Building, in Indianapolis, for the practice of internal medicine. He is a 1941 graduate of the University of Chicago School of Medicine, and served for four years in the Army. He recently completed postgraduate work in his specialty at the University of Chicago.

Dr. A. P. Warman has returned to the practice of medicine and surgery at 1361 East 38th Street, in Indianapolis. He has recently been in practice in Florida.

Dr. Henry N. McClelland has established offices in Decatur for the practice of medicine. A veteran of World War II, and a graduate of Indiana University School of Medicine, he has recently completed his internship at Indiana University Medical Center.

Dr. Francis Matychowiak has taken over the practice of **Dr. Jack Walker**, of Knightstown, who has been recalled to active duty with the U. S. Army Air Force. Doctor Walker has practiced in Knightstown since July, 1948. Doctor Matychowiak is a graduate of the University of Illinois School of Medicine, and interned at Indianapolis General Hospital.

Dr. Robert A. Morris, formerly of Anderson, has resumed the practice of pediatrics there. For the past six months he has been in practice in Dallas, Texas.

Dr. Edward Ponczek, of LaPorte, has opened an office in Monroeville for the general practice of medicine. He is a veteran of World War II, and a 1950 graduate of Indiana University School of Medicine. He served his internship at St. Margaret's Hospital in Hammond.

Dr. Howard Rothring, of Indianapolis, has moved to Columbus, where he will practice his specialty of radiology.

Dr. John R. Wagoner, of Colburn, has opened an office in Delphi. He is a graduate of Western Reserve University at Cleveland, and interned at St. Elizabeth Hospital in Lafayette. He has been in practice at Colburn for two years.

Dr. George M. Brother, former head of the preventive medicine section at the Indiana State Board of Health, is now serving in a similar capacity at the University of Oklahoma School of Medicine at Oklahoma City.

Dr. D. C. Barrett, of Indianapolis, who was in charge of local health services for the Indiana State Board of Health, has opened an office for private practice in Cincinnati.

Dr. Ralph M. Steffy, a native of Vincennes, has taken over the offices of **Dr. Basil B. Dulin** in Portland. Doctor Dulin has begun a three year course in radiology at the VA Hospital in Indianapolis. Doctor Steffy is a 1945 graduate of Indiana University School of Medicine, and served his internship at the Methodist Hospital in Indianapolis. He served with the U. S. Army Medical Department for two years, and has just completed a three year residency in internal medicine at the Methodist Hospital in Indianapolis.

Dr. Earl W. Sidebottom has announced the opening of an office for the practice of surgery at 1010 Hume Mansur Building, in Indianapolis. An Army veteran, Doctor Sidebottom is a 1944 graduate of Indiana University School of Medicine, and has taken postgraduate work at the Indiana University Medical Center and at the Methodist Hospital in Indianapolis.

Announcement has been made that **Dr. John S. Scott**, of Indianapolis, is now associated in practice with **Dr. A. R. Simon** at LaPorte. Doctor Scott is a specialist in radiology, and has been in practice in Indianapolis for ten years.

Dr. Frederick H. Simmons has announced his return to private practice in Marion. He practiced there for approximately a year before becoming attached to the Marion VA Hospital.

Announcement has been made that **Dr. J. W. Sibbitt** is now associated with **Dr. Dillon Geiger** in Bloomington, in the practice of otolaryngology, endoscopy and nasal allergy. Doctor Sibbitt is a graduate of Indiana University School of Medicine, and following his military service he took postgraduate work at the University of Illinois. He has just completed a residency in his specialty at the Hines Veterans Hospital in Chicago.

Dr. Myron J. VanDorn has opened an office at 3626 Clifton Street, in Indianapolis, for the practice of anesthesia.

FIRST $10,000 CRISS AWARD

Because of their brilliant work in the development and use of Cortisone, Dr. Philip S. Hench and Dr. Edward C. Kendall of the Mayo Clinic were named joint winners of the first Mutual of Omaha $10,000 Dr. C. C. Criss Award for outstanding contributions in the fields of public health and safety.

Presentation of the award was made at the meeting of the American Rheumatism Association at Atlantic City on June 9. Dr. E. L. Henderson, President of the American Medical Association, introduced Dr. N. L. Criss, Medical Director and Treasurer of Mutual of Omaha, who honored each of the winners with $5,000 and a gold medal.

A.M.A. WASHINGTON OFFICE NEWS

DETAILS OF AGED HOSPITALIZATION PLAN PROPOSED BY ADMINISTRATION

(Note: This is a condensed statement of facts and arguments advanced by FSA Administrator Oscar Ewing. No attempt is made in these pages to appraise the suggestion. This is merely a report on what the plan contains and on his explanation.)

Mr. Ewing, with administration support, has proposed a system of hospitalization for the aged and certain dependent groups. At this writing drafting of the bill has not been completed, but it likely will be introduced soon. Following are the main provisions:

PERSONS COVERED: All persons 65 and over (and their dependents) who are entitled to social security cash benefits, regardless of whether they actually are receiving benefits; widows under 65 with dependent children; any other survivors who are eligible for SS benefits under existing law.

BENEFITS: Sixty days hospital service in any one year; hospitals to be paid for services, drugs and appliances which the hospital customarily furnishes to its bed patients; specifically excluded are (1) medical care, except that generally furnished as an essential part of hospital care for bed patients, and (2) semi-private accommodations, unless the beneficiary himself is willing to pay the difference.

LIMITATIONS: While FSA would regard this hospitalization as the insured right of eligibles, not all could be taken care of. Because of wide variations in the rate of hospital occupancy, potential beneficiaries in certain areas would find it difficult, if not impossible, to obtain the service. Mr. Ewing explains that on the national average, hospitals are 71 or 72 percent occupied, whereas 85 percent is considered the practical maximum. In theory, beneficiaries would have access to this 13 or 14 percent not now occupied. Also, the program would not cover tuberculosis or mental patients, nor most chronic patients. Mr. Ewing said a chronic patient would be eligible if his condition became acute. However, he said specifically that rest homes and domiciliary homes could not participate.

ADMINISTRATION: At national level, the Federal Security Administrator or his agent would set policy; the Federal Hospital Council (of Hill-Burton program) would advise him, but would not have veto power. State health departments would be encouraged to handle the program and work out contracts with hospitals, but if a state declined to participate, individual hospitals would be authorized to deal directly with FSA. State-licensed hospitals would be eligible; if the state did not license, a participating hospital would have to meet standards set by FSA, in consultation with Federal Hospital Council. Mr. Ewing said provision would be made to keep patient records confidential, and to insure that the federal government would not control hospitals or participate in their policy-making.

FINANCING: The program would be financed by what Mr. Ewing describes as surplus in current social security collections from employers and employees. If, instead, these costs were to be assessed against payrolls, FSA experts estimate that the increase would be only $\frac{1}{10}$ of one percent on both employers and employes, an amount regarded by them as too small to justify the increase. Mr. Ewing said that this operation would not constitute use of funds legally earmarked or committed for other purposes. Total cost of the first year (probably 1953), is estimated at $200,000,000, a figure arrived at in this manner: By that year, about 7,000,000 persons would be eligible (5.5 million over 65). FSA planners, who said they were using insurance statistics as well as their own public welfare records, said they estimated the average person over 65 years required about two and a quarter days of hospitalization each year, with eligible younger adults and children averaging between half a day and a day. The total of these patient days, multiplied by an assumed hospital cost of $15 per day, produced the $200,000,000 estimate for the first year. It is contemplated that a hospital's patient day cost will be determined by averaging out its cost for "administration, dietary, housekeeping, nursing, x-ray laboratory, etc., but excluding costs for outpatients, research, etc."

CERTIFICATION: A patient would not be eligible for hospitalization until a physician had certified that this was necessary. It would be the responsibility of the physician to decide when a chronic case, ineligible for hospitalization, became an acute case, and therefore eligible. Under the plan, the physician himself would make arrangements for placing the patient in a hospital if space could be found.

ADMINISTRATION ARGUMENTS IN FAVOR OF PLAN: Sponsors emphasize that this plan would provide a form of hospitalization for groups of people least able to obtain nongovernment hospitalization (the aged) as well as those least able to afford such coverage (widows and dependents). Furthermore, they point out that this would mean a reduction in federal, state and local public welfare contributions. Mr. Ewing said, "Benefit checks (at current rate) cannot be stretched to cover unpredictable and heavy expense of illness requiring hospitalization." He cited several spot-check surveys of cities as evidence, including one which found that less than three-fifths of old age assistance beneficiaries were able to pay their expenses from their own resources when hospitalized. The sponsors report that only about 10 to 15 percent of the people over 65 have hospitalization insurance and believe that "even if voluntary hospitalization insurance were more readily available to older persons, limitations on the benefits—largely unavoidable in such policies—would discourage their purchase because such limitations greatly reduce the adequacy of the protection."

SPONSORSHIP: The plan has been under preparation for many months, with a number of outsiders, including some labor leaders, advising and assisting FSA officials. Mr. Ewing said at his press conference that he had also consulted with officials of the American Hospital Association and the Catholic Hospital Association. He did not say, however, that these groups supported the idea. Mr. Ewing said he had talked it over with a number of Senators and Congressmen before making the plan public officially. Asked if he thought there would be opposition, Mr. Ewing said, "I can't conceive that anyone with a heart would oppose this. This is something they will have paid for themselves in insurance . . . I can't believe doctors don't want sick people to have attention."

Deaths

Ada E. Schweitzer, M.D., a leader in child health work for many years, died on July 2, at the age of seventy-eight. As a tribute to her outstanding research work, the Army Medical Library requested her photograph, to be hung in the library. From 1919 to 1933 Doctor Schweitzer was head of the child hygiene division of the Indiana State Board of Health, and from 1933 to 1939 she did government public health work. She was a 1907 graduate from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis. She was an Honorary member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Allen H. Lee, M.D., of Terre Haute, died on July 1 in New York City, where he had gone for treatment. He was fifty-six years of age. He graduated from Indiana University School of Medicine in 1926, and had practiced in Terre Haute since 1927. He was a member of the Vigo County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Lester R. Mason, M.D., of Muncie, died on July 2, at the age of sixty-two. He had practiced in Muncie ever since his graduation from Indiana University School of Medicine, in 1925. He was a member of the Delaware-Blackford County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Jake D. Ruch, M.D., of Indianapolis, died suddenly on June 22, at the age of twenty-seven. He was a 1947 graduate of Indiana University School of Medicine, and would have completed a three year residency in internal medicine at Indianapolis on June 30. He was preparing for entrance into the U. S. Air Force. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Benjamin E. Duke, M.D., of Decatur, died on June 15, at the age of fifty. He was a graduate of the University of Louisville School of Medicine in 1925, and had practiced in Crab Orchard and Lebanon Junction, Kentucky, and in Monroeville, before going to Decatur in 1934. Doctor Duke was a member of the Adams County Medical Society, the Indiana State Medical Association, and the American Medical Association.

William F. Duncan, M.D., of Aurora, died on June 29. He was eighty-six years of age and had practiced for approximately sixty years. He graduated from the Miami Medical College at Cincinnati in 1892, and practiced in Sparta, Kyle and Manchester. Doctor Duncan was an honorary member of the Dearborn-Ohio Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Moses A. Farver, M.D., of Middlebury, died on June 29 after a long illness. He was eighty-four years of age. He was a graduate of the Baltimore Medical College in 1893, and had practiced in Middlebury since 1895. Doctor Farver was an Honorary member of the Elkhart County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Claude E. Hadden, M.D., of Indianapolis, died suddenly on June 20, at the age of fifty-four. He was a 1925 graduate of the Indiana University School of Medicine, and had practiced in Indianapolis since that time. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association.

Milo O. King, M.D., of Rochester, died on July 4, at the age of eighty-two. After graduating from Rush Medical College, in Chicago, in 1896, he began the practice of medicine in Rochester, where he remained ever since. He was a member of the Fulton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

May 26, 1951.

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; Alfred Ellison, M.D.; J. William Wright, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guests: James M. Kirtley, M.D., chairman, Committee on Medical and Nursing School Scholarships
Maurice V. Kahler, M.D., member of Committee on Physician-Hospital Relationship
C. H. Rommel, M.D., president, Indiana Academy of General Practice
Cleon A. Nafe, M.D.) delegate and
Karl R. Ruddell, M.D.) alternate to the AMA.

Membership Report—

Number of members May 26, 1951	3,432*
Number of members May 26, 1950	3,515
Loss over last year	83
Number of members December 31, 1950	3,689

* Includes 45 in military service (gratis)
123 $10.00 members (residents and interns)
185 senior members
26 members, dues remitted by Council

Number who have paid 1951 AMA dues	2,703
Number who paid 1950 AMA dues	2,797

Statements of receipts and expenditures were approved.

1951 Annual Session, Indianapolis
October 29, 30 and 31, 1951

Banquet. Persons sitting at the speakers' table are to be asked to dress formally, on motion of Drs. Ellison and Wright.

Fifty-Year Club reception. On motion of Drs. Clark and Kennedy the association is to bear the expenses of the reception for the Fifty-Year Club members rather than the Convention Arrangements Committee.

Legislative Matters

On motion of Drs. Ellison and Wright the committee voted to continue the subscription to Washington Report on Medical Sciences.

Organization Matters

Indiana Foundation for Health. Because of the inability of Dr. Louis E. How, chairman of the Committee on Rural Health, to be present, action on the proposed by-laws of the Indiana Foundation for Health was postponed until the next meeting.

Membership problems.

a. *AMA Associate Fellows.* On motion of Drs. Clark and Myers the following Hoosier physicians were approved for Associate Fellowship in the American Medical Association:

W. D. Asbury, Terre Haute
Charles R. Bird, Indianapolis
Samuel J. Copeland, Indianapolis
W. N. Culmer, Bloomington
M. F. Daubenheyer, Richmond
G. R. Douglas, Valparaiso
W. L. Green, Pekin
Merle D. Gwin, Miami Beach, Fla.
(formerly of Rensselaer, Ind.)
John A. Kent, Mulberry
A. R. Logan, Petersburg
J. R. Pearson, Bedford
C. W. Rutherford, Indianapolis
E. M. Shanklin, Hammond
S. J. Young, Kendallville

Physician-Hospital Relationship Survey. After Drs. Kahler and Rommel presented information they had gathered on physician-hospital relationship from various cities throughout the state, pointing to the desire for representation of general practitioners as members of the proposed hospitals standardization commission, Drs. Wright and Kennedy moved that it is the consensus of the Executive Committee that a generous number of the representatives of the American Medical Association on this commission be general practitioners. Dr. Nafe, who will serve as one of Indiana's delegates to the AMA meeting at Atlantic City in June, said he would introduce a resolution to this effect in the House of Delegates meeting.

Letter of Committee on Physician-Hospital Relationship. A letter which the Committee on Physician-Hospital Relationship proposes to send to hospital administrators and chairmen of boards of trustees was approved on motion of Drs. Ellison and Clark, after a suggested change in wording in paragraph No. 3.

Starke County welfare situation. The executive secretary was directed to send a copy of a letter received from Maurice O. Hunt, welfare administrator, in which he asked for better cooperation of Starke County physicians with the Starke County Welfare Department to the president of the Starke County Medical Society.

On motion of Drs. Clark and Wright the Executive Committee approved the list of towns in

SEARLE RESEARCH CREATED "Smoothage"

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

METAMUCIL® —the refined bulk or "smoothage" principle now recognized as a preferred treatment for constipation—originated from Searle Research.

METAMUCIL is of plant origin—it adds necessary natural bulk to the food residue

is free of all forms of irritating substances

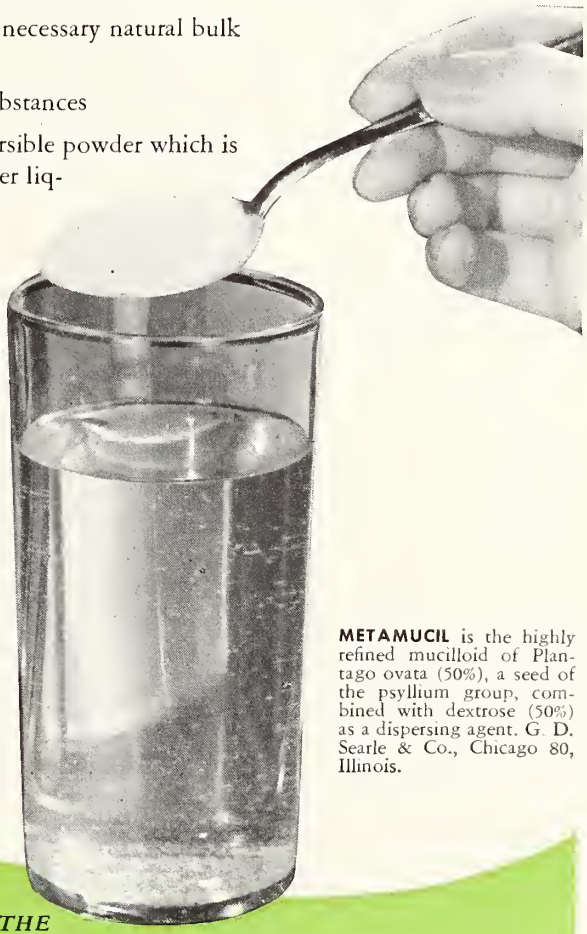
is prepared only in an easily dispersible powder which is taken with a glass of water or other liquids—one of the prime requisites to successful bowel management.

is economical—one teaspoonful one to three times a day in a glass of liquid is the indicated daily dose

enables the physician to use the "smoothage" principle of restoring normal bowel function

provides a bland water-retaining demulcent mass which mixes intimately with food and does not interfere with the digestion or the absorption of oil soluble vitamins.

METAMUCIL IS A *PROFESSIONAL PRODUCT.*



METAMUCIL is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE *RESEARCH IN THE SERVICE OF MEDICINE*

critical need of physicians, as prepared by the Committee on Medical and Nursing School Scholarships, for submission to the two medical school scholarship recipients who are completing internships this summer.

American Medical Education Foundation. As of May 10, 1951, $221.00 had been received from physicians in Indiana by this organization.

Meeting with Woman's Auxiliary. The request of the president of the Woman's Auxiliary for officers of the Auxiliary to meet with the Executive Committee on Sunday, June 24, 1951, was approved. The women are to be invited for dinner at 12:30 p. m., and the afternoon is to be devoted to discussion of the 1951-52 Woman's Auxiliary program.

On motion of Drs. Kennedy and Wright the Executive Committee is to recommend to the Council that the Council insist that AMA delegates attend Council meetings.

The Journal

Report on advertising:

May, 1951	$ 2,333.53
May, 1950	2,236.27
Gain over last year	$ 97.26
Five-month total, 1951	$11,245.18
Five-month total, 1950	10,800.85
Gain	$ 444.33

There being no further business, the committee adjourned to meet again on Sunday, June 24, 1951, at 10:00 a.m. at the Columbia Club, Indianapolis.

EXECUTIVE COMMITTEE

June 24, 1951.

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; Alfred Ellison, M.D.; J. William Wright, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D.

Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guests: Louis E. How, M.D., chairman, Committee on Rural Health
James M. Kirtley, M.D., chairman, Committee on Medical and Nursing School Scholarships

Membership Report

Number of members June 22, 1951	3,515*
Number of members June 22, 1950	3,595
Loss over last year	80
Number of members December 31, 1950	3,689

*Includes 46 in military service (gratis)
133 $10.00 members (residents and interns)
197 senior members
31 members, dues remitted by Council

Number who have paid 1951 AMA dues	2,760
Number who have paid 1950 AMA dues	2,814

1951 Annual Session, Indianapolis
October 29, 30 and 31, 1951

Booth space, Indiana Academy of General Practice. On motion of Drs. Ellison and Clark the request of the Indiana Academy of General Practice for booth space was approved providing that there is no acceptance of money at the booth for membership in the Academy, and only literature of an educational nature is distributed.

Fifty-Year Club response. Dr. Charles E. Gillespie of Seymour was selected to make the response for the Fifty-Year Club members at the annual dinner, on motion of Drs. Clark and Kennedy.

General Practitioner of the Year Award. On motion of Drs. Kennedy and Ellison it was voted to purchase a painting by a Brown county artist for the Family Doctor of the Year award, at a cost of $50.00, and Dr. A. F. Weyerbacher is to be asked to make the selection.

Statements of receipts and expenditures were approved.

Organization Matters

Indiana Foundation for Health. After the proposed by-laws of the Indiana Foundation for Health were explained by the chairman of the Committee on Rural Health they were approved on motion of Drs. Kennedy and Clark. On motion of Drs. Kennedy and Ellison, a recommendation is to be made to the Council that $5,000 be appropriated for the association's participation the first year, providing other participating organizations contribute proportionate amounts.

Student loan fund. On motion of Drs. Clark and Ellison the Executive Committee is to recommend to the Council that the Council recommend to the House of Delegates that the student loan fund which replaced the medical and nursing school scholarships be discontinued. The suggestion was made to the chairman of the Committee on Medical and Nursing School Scholarships that no loans be made pending action of the Council and the House of Delegates on the Executive Committee's recommendation.

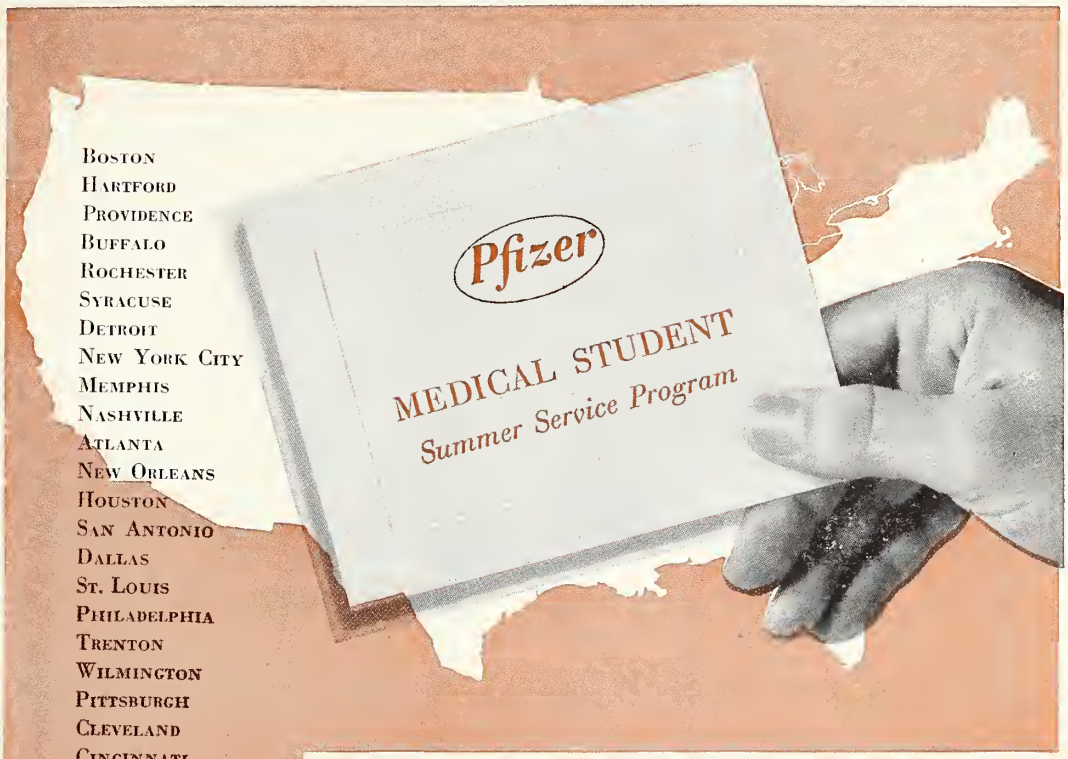
Local Agents Plan of Hoosier Casualty Company. Letter concerning the Local Agents Plan from the Gibson County Medical Society to the Hoosier Casualty Company of Indianapolis was read.

The Journal

Report on advertising:

June, 1951	$ 2,102.49
June, 1950	2,247.53
Loss over last year	$ 145.04

(Continued on page 788)



BOSTON
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NEW YORK CITY
MEMPHIS
NASHVILLE
ATLANTA
NEW ORLEANS
HOUSTON
SAN ANTONIO
DALLAS
ST. LOUIS
PHILADELPHIA
TRENTON
WILMINGTON
PITTSBURGH
CLEVELAND
CINCINNATI
CHICAGO
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PORTLAND
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FRESNO

A PIONEER group of 70 medical students, 3rd and 4th year leaders from some of the nation's outstanding medical schools, have been selected for a special course in antibiotics covering recent research and clinical developments. These young men and women are qualified to serve physicians in 36 major cities during their summer vacation and will make available reprints, abstracts, bibliographic research and other data as requested by members of the profession.

At the same time they have the invaluable opportunity of acquainting themselves with current clinical practices of leading general practitioners, specialists, teaching institutions and other professional groups.

This new Pfizer activity will supplement other Pfizer services such as the Antibiotics Newsletter, now being prepared and distributed semi-monthly by the Medical Service Department.

ANTIBIOTIC DIVISION Pfizer CHAS. PFIZER & CO., INC., *Brooklyn 6, New York*

(Continued from page 786)

Six-month total, 1951	$13,347.67
Six-month total, 1950	13,048.38
Gain	$ 299.29

There being no further business the committee adjourned to meet again on Saturday, July 14, 1951, at 6:30 p. m. at the Athenaeum, Indianapolis.

LOCAL SOCIETY REPORTS

Dubois County Medical Society members and members of the Woman's Auxiliary held a joint dinner meeting at the American Legion Club on June 14. Twelve members were present to hear a discussion of hospital pharmacy. Members of the auxiliary held a separate business meeting.

Fayette-Franklin County Medical Society members held their regular meeting at the Mound Hotel in Brookville on June 12. The guest speaker was Dr. Robert Green, of Cincinnati, who discussed coronary heart disease. Fifteen members were present.

Gibson County Medical Society members met at the Hotel Emerson in Princeton on June 5. Dr. Henry A. Springer, of Cincinnati, was the guest speaker. He discussed the most recent trends in fracture treatment. Twenty-five members and guests were present.

Wayne-Union County Medical Society members held a dinner meeting at the Coliseum in Liberty. Dr. Rollo Harger, of Indianapolis, was the guest speaker.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. F. M. Fargher, Michigan City.

President-Elect—Mrs. Hubert T. Goodman, Terre Haute.

Corresponding Secretary—Mrs. Victor F. Kling, Michigan City.

Recording Secretary—Mrs. Elmer Singer, Fort Wayne.

Treasurer—Mrs. Robert Bolin, Elkhart.

The 28th annual convention of the Woman's Auxiliary to the American Medical Association met in Atlantic City, New Jersey, June 11 to June 15.

On Monday morning the pre-convention activities included a meeting of the Board of Directors and round table discussions by National Committee Chairmen on Program, Legislation, Public Relations and *Today's Health*. In the afternoon a lovely tea honoring Mrs. Arthur A. Herold, president, and Mrs. Harold F. Wahlquist, president-elect, was given by members of the Woman's Auxiliary to the Medical Society of New Jersey. All doctors' wives were invited. In the evening the auxiliary members, accompanied by their husbands, attended a fashion show at Convention Hall. The show, presented in a garden setting, was keyed to the activities of a summer bride from her engagement to the church wedding.

The formal opening of the convention was at 9 A.M. Tuesday morning, with Mrs. Arthur A. Herold presiding. This session was devoted to reports from national officers, national committee chairmen and state presidents. The Indiana report was given by our immediate past president, Mrs. D. E. Lybrook. Indiana's delegates swelled with pride as she recounted the fine progress made by our auxiliaries in 1950-51, especially the fact that we had no red dots in Indiana on the big organization map displayed by the National Organization Chairman. This means that Indiana has either an auxiliary or members-at-large in every county in the state.

This year the state reports were given by geographical areas so that neighboring states might benefit from an exchange of ideas suitable for their own region.

The business sessions continued through Wednesday and Thursday. The by-laws were amended, resolutions adopted and new officers elected. We heard discussions by George Larson, assistant director of the American Medical Association's Scientific Exhibits, and Dr. Ernest B. Howard, assistant secretary of the American Medical Association. Mr. Larson illustrated with colored slides the exhibits available to auxiliaries to assist with health education campaigns. Dr. Howard discussed current national legislation, stressing especially the dangers in S. B. 337, on Federal Aid to Medical Education.

The luncheon meetings were a combination of business and entertainment. National past presidents were honored on Tuesday, with Mr. Ed. Lipscomb, Memphis, Tennessee, Director of Public Relations, National Cotton Council, as the main speaker. Wednesday's luncheon was highlighted by the presentation of a check for $10,000 from the auxiliary to Dr. Elmer Henderson, president of the American Medical Association, to assist the association in its fight for independent medical education.

Guests of honor were Dr. Henderson, president, American Medical Association; Dr. John W. Cline, president-elect; Dr. Louis H. Bauer, chairman of the Board of Trustees; Dr. R. B. Robins, vice president; Dr. George F. Lull, secretary and general manager; Dr. Ernest B. Howard, assistant secretary; Dr. J. J. Moore, treasurer; Dr. F. F. Borzell, speaker House of Delegates; Dr. Austin Smith, editor; and the members of the Advisory Council to the Woman's Auxiliary.

Mrs. D. E. Lybrook, our immediate past-president, entertained Indiana delegates at a delightfully appointed early bird breakfast, Wednesday morning. Those in attendance were Mrs. W. J. Stangle and Mrs. Neal Baxter, Bloomington; Mrs. F. M. Gastineau and Mrs. Lester Bibler, Indianapolis; Mrs. Truman Caylor and Mrs. Robert Johnston, Bluffton; Mrs. Ivan Gilbert and Mrs. John M. Sullivan, Terre Haute; Mrs. Robert Bolin and Mrs. Richard Stout, Elkhart; Mrs. George Ritterman, Columbus; and Mrs. F. M. Fargher, Michigan City.

The business session adjourned at noon Thursday with the installation of the new president, Mrs. Harold F. Wahlquist of Minneapolis. At this time Mrs. Truman Caylor received an appointment as National Finance Chairman. This is a great honor for Indiana and gives us two representatives in the National Auxiliary family since Mrs. Frank Gastineau is beginning her second term as a National Director. In her inaugural address Mrs. Wahlquist set the keynote for next year's activities.

Emphasis will be placed on nurse recruitment, rural health, voluntary health insurance and auxiliary participation in civil defense in all communities. Two other phases of the auxiliary's program for the coming year were stated in resolutions adopted at this session. The first resolved that the auxiliary support the American

for a sound mind and healthy body

plenty of citrus fruit

Diets restricted because of allergies, diabetes, ulcers, etc. are frequently low in vitamin C[1,3,5]—thus adding a nutritive deficiency to the existing condition.[8] In gastric and duodenal ulcers,[2] a subscorbutic state is particularly serious because it interferes with collagen formation and capillary integrity.[3] Florida orange juice alone—or with milk to prevent a possible "burning" sensation—is not only a palatable source of vitamin C, but a quick means for providing an energizing "lift"[5,7] produced by the easily assimilable fruit sugars.[6] Fortunately Florida orange juice is virtually non-allergenic.[4]

FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

Citrus fruits—among the richest known sources of vitamin C—also contain vitamins A and B, readily assimilable natural fruit sugars, and other factors, such as iron, calcium, citrates and citric acid.

REFERENCES:

1. Bicknell, F. and Prescott, F.: The Vitamins in Medicine, 2nd ed., Heinemann, 1946.
2. Bunnigan, W. M. et al: Ohio J. Sc. 44:123, 1944.
3. Ivy, A. C. et al: Peptic Ulcer, Blakiston, 1950.
4. Jeans, P. C. and Marriott, W. McK.: Infant Nutrition, Mosby, 1947.
5. Jolliffe, N. et al, ed.: Clinical Nutrition, P. B. Hoeber, 1950.
6. McLester, J. S.: Nutrition and Diet in Health & Disease, 4th ed., Saunders, 1944.
7. Sherman, H. C.: Chemistry of Food and Nutrition, 7th ed., Macmillan, 1946.
8. Spies, T. D.: J.A.M.A. 122:497, 1943.



FLORIDA

Oranges • Grapefruit Tangerines

Medical Association's Educational Fund with personal annual contributions by county medical society members. The second maintained that the Woman's Auxiliary to the American Medical Association continue to activate itself against the insidious efforts of the socializers by maintaining contacts with woman's clubs, by distribution of informative material, by speeches before lay groups and other constructive and educational methods.

On Thursday evening auxiliary members entertained their husbands and guests at the annual auxiliary dinner. From there they went to the reception and ball in honor of Dr. J. W. Cline, newly installed president of the American Medical Association.

Convention statistics showed a registration of 1,578 delegates and guests from 48 states, the District of Columbia, Alaska and Hawaii.

HELEN L. FARGHER, President.

Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOKS RECEIVED

PRINCIPLES AND PRACTICE OF OBSTETRICS. Tenth Edition. Originally by Joseph B. De Lee, M.D. By J. P. Greenhill, M.D., Chicago. 1020 pages, with 1140 illustrations on 864 figures, 194 in color. Price $12.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, 1951.

THE NEUROSES—Diagnosis and Management of Functional Disorders and Minor Psychoses. By Walter C. Alvarez, M.D., the Mayo Clinic. 667 pages. Price $10.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, 1951.

A TEXTBOOK OF MEDICINE. Eighth Edition. Edited by: Russell L. Cecil, M.D., Cornell University, New York, and Robert F. Loeb, M.D., Columbia University, New York. 1627 pages, 204 figures, 40 tables. Price $12.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, 1951.

CLINICAL HEART DISEASE. Fourth Edition. By Samuel A. Levine, M.D., Boston, Mass. 556 pages with 192 figures. Price $7.75. W. B. Saunders Company, West Washington Square, Philadelphia 5, 1951.

HANDBOOK OF NUTRITION. Second Edition. Prepared under the auspices of the Council on Foods and Nutrition of the A.M.A. 717 pages, with 7 charts, 28 tables, 35 figures. Price $4.50. The Blakiston Company, 1012 Walnut St., Philadelphia 5, 1951.

PRACTICAL CLINICAL PSYCHIATRY. Seventh Edition. By Edward A. Strecker, M.D., School of Medicine, University of Pennsylvania; Franklin G. Ebaugh, M.D., University of Colorado, School of Medicine; and Jack R. Ewalt, M.D., University of Texas Medical Branch. 506 pages with 35 figures and 14 tables. Price $7.00. The Blakiston Company, 1012 Walnut Street, Philadelphia 5, 1951.

ANATOMY IN SURGERY. By Philip Thorek, M.D., University of Illinois College of Medicine. 970 pages, with 720 illustrations, 211 in color, drawn by Carl T. Linden, instructor in medical illustration, University of Illinois College of Medicine. Price $22.50. J. B. Lippincott Company, East Washington Square, Philadelphia, 1951.

MANAGEMENT OF CELIAC DISEASE. By Sidney V. Haas, M.D., New York Polyclinic Medical School; and Merrill Haas, M.D. 188 pages, with 12 illustrations. Price $5.00. J. B. Lippincott Company, East Washington Square, Philadelphia, 1951.

PHILOSOPHY FOR THE COMMON MAN. By Heinrich F. Wolf, M.D. 189 pages. Price $3.50. Philosophical Library, Inc., 15 East 40th Street, New York 16, 1951.

SPATIAL VECTOR ELECTROCARDIOGRAPHY. By Robert P. Grant, M.D., and E. Harvey Estes, Jr., M.D., Bethesda, Maryland. 149 pages with 41 figures. $4.50. The Blakiston Company, 1012 Walnut Street, Philadelphia 5, 1951.

HANDBOOK OF MEDICAL MANAGEMENT. Second Edition. By Milton Chatton, M.D., and Sheldon Margen, M.D., both of the University of California Medical School and Henry D. Brainerd, M.D., of Stanford University School of Medicine. 510 pages. Price $3.00. University Medical Publishers, P. O. Box 761, Palo Alto, California, 1951.

HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES. By Adolph G. DeSanctis, M.D., and Charles Varga, M.D., both of New York University-Bellevue Medical Center. 284 pages, with 51 illustrations. Price $5.00. The C. V. Mosby Company, St. Louis, 1951.

DIABETES MELLITUS—Principles and Treatment. By Garfield G. Duncan, M.D., Jefferson Medical College, Philadelphia. 289 pages with 31 figures and 40 tables. Price $5.75. W. B. Saunders Company, West Washington Square, Philadelphia 5, 1951.

IMMUNOLOGY. Third Edition. By Noble P. Sherwood, M.D., University of Kansas, Lawrence, Kansas. 731 pages, with 21 figures and 7 color plates. Price $8.00. The C. V. Mosby Company, St. Louis, 1951.

THE MICROKARYOCYTES, THE FOURTH CORPUSCLES AND THEIR FUNCTIONS. By H. G. Khorozian, M.D., Pineville, West Virginia. 969 pages, 480 pictures—many enlarged 25,000 times. Price $12.00. Meador Publishing Company, 324 Newbury Street, Boston 15. Copyright by the author, 1951.



Growth Rates
AND IMPROVED NUTRITION

ACCORDING to an eminent authority,[1] increased growth rates of children are largely attributable to improved nutrition; also, "much evidence exists that current diets are often unsatisfactory." The nutrients most commonly deficient in diets of children are protein, calcium, thiamine, riboflavin, and ascorbic acid.

Ovaltine in milk—a palatable food supplement, readily accepted by children and easily digested—presents an excellent means of helping to bring even grossly deficient diets to optimal nutritional levels. It provides a wealth of biologically adequate protein, easily emulsified fat, readily utilized carbohydrate, and essential vitamins and minerals. The addition of three servings daily to the child's diet, either at mealtime or between meals, assures nutrient intake in keeping with the dietary allowances of the National Research Council—an essential for promoting optimal growth rate.

The nutrient contribution of three servings of Ovaltine in milk is defined in the appended table.

1. Jeans, P. C.: Feeding of Healthy Infants and Children, J.A.M.A. *142*:806 (Mar. 18) 1950.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.



Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk, provide:*

PROTEIN	32 Gm.	VITAMIN A	3000 I.U.
FAT	32 Gm.	VITAMIN B_1	1.16 mg.
CARBOHYDRATE	65 Gm.	RIBOFLAVIN	2.0 mg.
CALCIUM	1.12 Gm.	NIACIN	6.8 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN C	30.0 mg.
IRON	12 mg.	VITAMIN D	417 I.U.
COPPER	0.5 mg.	CALORIES	676

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

BOOKS REVIEWED

THE BASES OF HUMAN BEHAVIOR. A Biologic Approach to Psychiatry. By Leon J. Saul, M.D., Professor of Clinical Psychiatry, University of Pennsylvania School of Medicine. 150 pages. Price $4.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, 1951.

This book is an introduction to the biologic bases of psychodynamics. Written in connection with medical teaching, it is designed to provide, in simple form, the fundamental knowledge upon whch modern psychiatry rests. It integrates the psychological sciences with those of biology as anatomy and physiology.

Its purpose is to give the reader an appreciation of the reality of the emotional forces within the mind, their sources in the biology of the organism and something of their relationship to its physiologic functoning. It aims also to convey the present-day concept of the structure and the development of the mind.

It should prove to be of service to all who are interested in the science of human nature.

T. M. C.

MEDICINE OF THE YEAR. Third issue; 1951. Editorial direction by John B. Youmans, M.D., Dean of the School of Medicine, Vanderbilt University. 298 pages. Price $5.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, 1951.

This is the third issue of this annual.

In reporting recent discoveries and progress in medicine, surgery, and the specialties, this book is unique in its organizaton and method of presentaton.

Each of eighteen fields of medicine is discussed by a competent specialist. He first introduces his section by a summarized statement of what the reader is to find contained in the body of the discussion which immediately follows. This gives at a glance the "meat" of the chapter and orients the reader as to what facts, in the judgment of the author, are important and remarkable.

The discussion portion of each chapter is a condensed analysis of the trend of developments, the meaning of new discoveries or theories, the results of treatment to be expected, the probable value of diagnostic aids, the prognostic significance of observations and tests, etc. This survey of the field, digesting of material, discriminating between the valuable and the less important reports, and the final synthesizing of much information is a service rendered by the respective authors, much appreciated by the average physician who would like to do the same study first hand, but who just does not take time for such labor.

Each chapter is generously supplied with key references to the original literature for those interested in more detailed study.

The overall style of the book is good. The print is easily read, in double column pages. Bold print subtitles sharply contrast portions of each chapter. It contains both author and subject indexes.

—T.M.C.

HOSPITAL STAFF AND OFFICE MANUAL. By Tadeusz M. Larkowski, M.D., F.A.C.S. and Albert R. Rosanova, R. Ph., M.D. 428 pages and hundreds of illustrations. Price $4.95. Romaine Pierson Publishers, Inc., 690 Northern Boulevard, Great Neck, L. I., New York, 1951.

For the intern, busy practitioner, medical student or nurse, this book is interesting and useful as a reference manual. Although no subject is treated comprehensively, almost every subject in medicine and surgery and many laboratory procedures are mentioned. The material is well presented in 413 pages; it contains many illustrations and a comprehensive index. The book has a flexible, waterproof, artificial leather cover, and can be carried in the pocket.

D. A. B.

PARACELSUS—Magic Into Science. By Henry M. Pachter. 360 pages. 11 illustrations. Price $4.00. Henry Schuman, Inc., 20 East 70th Street, New York 21, 1951.

This book is a character sketch of a fascinating man as he struggles to find truth in an age in which magic was turning into science. The central interest of the author in this biography lies in watching that transition at its turning point. As such, he has written a readable book, stimulating to the more mature physician who likes to read medical history for pleasure.

As a reference to the Renaissance and the Reformation this book explains and correlates many facts otherwise difficult to understand. The author makes ample use of notes, appendices, and bibliography for the more academic student's reference. These are not allowed to disturb the continuity of the presentation.

The author vividly portrays the times so that the reader appreciates more fully the paradox of the life of Paracelsus, the great impact of whose life is stressed by the linkage of his feats to the legendary Faust of literature.

But one does not lay this book aside as mere biography and history; one reads it again as a revelation of a man's struggle to emerge above his environment into a better and more scientific world. As the reader gains insight to the character of Paracelsus living his troubled life and striving to win salvation through science, he becomes keenly aware that the book contains much that most physicians of all times respond to with sympathetic rapport. Through identification the reader relives his own life as contrasted with that of Paracelsus. He questions his own mind and soul, analyzes his own scientific knowledge, and reviews his own concepts of medical practices, beliefs and disbeliefs in humanity, faith and religion. Like the alchemist brewing mysterious and wonderful essences, the reader is stimulated to experiment with his own thoughts, to amalgamate them with that which he finds good, and to compound an alloy which to him becomes his own philosopher's stone of truth.

T. M. C.

The "estrogen preferred by us is 'Premarin,' a mixture of conjugated estrogens, the principal one of which is estrone sulfate."

Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

In treating the menopausal syndrome with "Premarin," Perloff* reports that "Ninety-five and eight tenths per cent of patients treated with 3.75 mg. or less daily obtained complete relief of symptoms"; also, "General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Thus, the sense of "well-being" usually imparted represents a "plus" in "Premarin" therapy which not only gratifies the patient but is conducive to a highly satisfactory patient-doctor relationship.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

"PREMARIN"®

"Premarin" contains estrone sulfate plus the sulfates of equilin, equilenin, β-estradiol, and β-dihydroequilenin. Other α- and β-estrogenic "diols" are also present in varying amounts as water-soluble conjugates.

Estrogenic Substances (water-soluble) also known as Conjugated Estrogens (equine)

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BOOKS REVIEWED

TREPHINE TECHNIQUE OF BONE MARROW INFUSIONS AND TISSUE BIOPSIES. By Henry Turkel, M.D., 650 Boston Boulevard, Detroit 2. Fourth Edition. 60 pages, and approximately 25 illustrations. Copyright 1950 by author. Copies may be obtained at $1.00 each from Trephine Instruments, Inc., 1301 Industrial Bank Bldg., Detroit 26.

This is a well prepared and well organized manual introducing to the medical profession a simple method of infusion and of obtaining biopsy material from certain sites. The advantages, disadvantages, and the instruments are presented and discussed in a simple direct outline form.

The increasing use of biopsy material for the purpose of following the course of disease as well as for diagnosis has stimulated the search for newer instruments and methods. The Turkel biopsy instruments have provided a simple safe means of obtaining such material with a minimum of distortion and without the more difficult and extensive surgical procedures. It must be kept in mind that the material obtained represents only a small portion of the total organ and that the absence of positive findings does not necessarily mean that the organ is not involved in disease.

Bone marrow infusions, however, are not done without some dangers. If used as indicated by the author and with the methods advised, they become a valuable adjunct to therapeutic technique.

This is a good manual for those who are interested in simple safe biopsy techniques.

L. G. M.

HUMAN GROWTH. By Lester F. Beck. 124 pages including glossary. Price $2.00. Harcourt, Brace and Company, New York.

All who have seen the widely known and widely acclaimed documentary film "Human Growth" will have an enthusiastic welcome for its companion book, "Human Growth" which covers the same subject in almost exactly the same way. The only difference, really, is that the one is a book, and the other is a moving picture. For those who have never seen the movie the book will be a revelation in the carefully controlled teaching technic of sex education. A long time project supported by the E. C. Brown Trust Foundation the movie "Human Growth" has been widely used in schools. The book "Human Growth" has been made possible by the same fund, and fills a long felt need for accurate, well illustrated, understandable and inexpensive text on sex education for use in the same educational areas served by the correlary film. The method of presentation makes the book useful, not only as a text for school classes, but as a guide to parents who rightly want to guide their childrens' thinking themselves, as a reading book for children, and/or a service book for all who are involved in the teaching of children.

No one who is involved in the teaching of children can be without this excellent book.

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BOOKS REVIEWED

CANCER AS I SEE IT. By Henry W. Abelmann, M.D. 100 pages. Price $2.75. The Philosophical Library, Inc., 15 East 40th Street, New York 16, 1951.

This small volume is the author's idea of the nature of cancer. He attempts to prove that cancer is a virus disease, claiming to have produced carcinoma, sarcoma, leukemia, pernicious anemia and inflammatory tumors by the inoculation of a mold organism derived from human cancer tissue. It is unfortunate that this work was not previously reported, and corroborated by other investigators. Extensive research is being carried on in various laboratories on the virus cause of cancer with the aid of the electron microscope.

It is difficult to assess what contribution this work makes to medical literature.

D. A. B.

CHILD PSYCHIATRY IN THE COMMUNITY. By Harold A. Greenberg, M.D., senior staff psychiatrist, Institute for Juvenile Research, Chicago. 296 pages. Price $3.50. G. P. Putnam's Sons, 2 West 45th Street, New York City, 1950.

This book, which is a primer for teachers, nurses



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BOOKS REVIEWED

and others who care for children, is written in a pleasing and interesting manner. Personality development of the child, psychogenesis of behavior problems, symptoms, diagnosis, prognosis and treatments as carried out in a child guidance clinic are discussed in a comprehensive manner.

The functions of the clinic team, made up of the psychiatrist, psychologist and social worker, are discussed in a clearcut manner. The relationships between the clinic and community as well as the role of the nurse and teacher in child guidance are also discussed. The author points out that child psychiatry is a new science and that ideas, techniques and methods will continue to change. However, in spite of these changes, the guiding principle will always remain the same; the needs of children must be understood, and they and their parents must be assisted to this understanding so that these needs can be healthily and properly met.

The author and his collaborators have assembled in one volume a concise description of all the various aspects of child psychiatry. A minimum of technical phraseology, descriptive clarity and interesting presentation of clinical material makes this book one of the best in its field. The book is highly recommended as a guide to the individual who is interested in furthering the emotional development of the child. M.F.G.

PRENATAL CARE SAVES EXPECTANT MOTHERS WITH HEART CONDITIONS

Adequate prenatal care of the expectant mother suffering from heart disease will reduce the maternal mortality rate of such patients, according to a report in the July 7 *Journal of the American Medical Association.*

Four Chicago doctors—James E. Fitzgerald, Augusta Webster, Bruce P. Zummo and Philip C. Williams—studied the records of the Cook County Hospital, Chicago, over an 11-year period (July 1936 to July 1947). They found that deaths of such mothers usually occur among those with inadequate or no care during pregnancy.

The hospital's records showed 55,938 mothers were delivered of viable infants. Of these women, 704 had organic heart disease. The hospital's cardiac clinic treated 460 prenatally; 244 were not seen by the clinic.

"It is evident from the material reviewed that there were many with severe cardiac disease among the 460 women with organic heart defects followed in the prenatal cardiac clinic," the report said. "However, all these women, with three exceptions, were delivered safely.

"There were 244 women with organic heart disease who were not seen in the cardiac clinic, and from this group there were 21 deaths."

The Chicago doctors pointed out that marriage and pregnancy call for a re-evaluation of the functional capacity of a woman's heart. The pre-pregnancy classification offers a good index of what may be expected, they said.

In the treatment of pregnant women with heart conditions, the clinic uses a diet which supplies food essentials but which at the same time avoids causing digestive distress. Usually it is low in caloric value, salt and fat, moderate in carbohydrate and high in protein. Every effort is made to keep the patient's total weight gain at 20 pounds.

Bed rest is encouraged. All patients are asked to rest one hour and preferably two each afternoon. They are instructed to sleep at least eight hours each night.

"Bed rest constitutes the most effective single therapeutic agent in the treatment of heart disease," it was pointed out. They added:

"Care of the cardiopath does not cease with delivery. We have seen women deliver without difficulty and later show signs of decompensation. Sepsis is especially guarded against. Mild sedation is maintained, and longer periods of bed rest are required than for normal women."

Patients are not discharged until adequate circulation is established. They are released with instructions on dietary and therapeutic management and are requested to report to the clinic in two weeks for follow-up care and observation.

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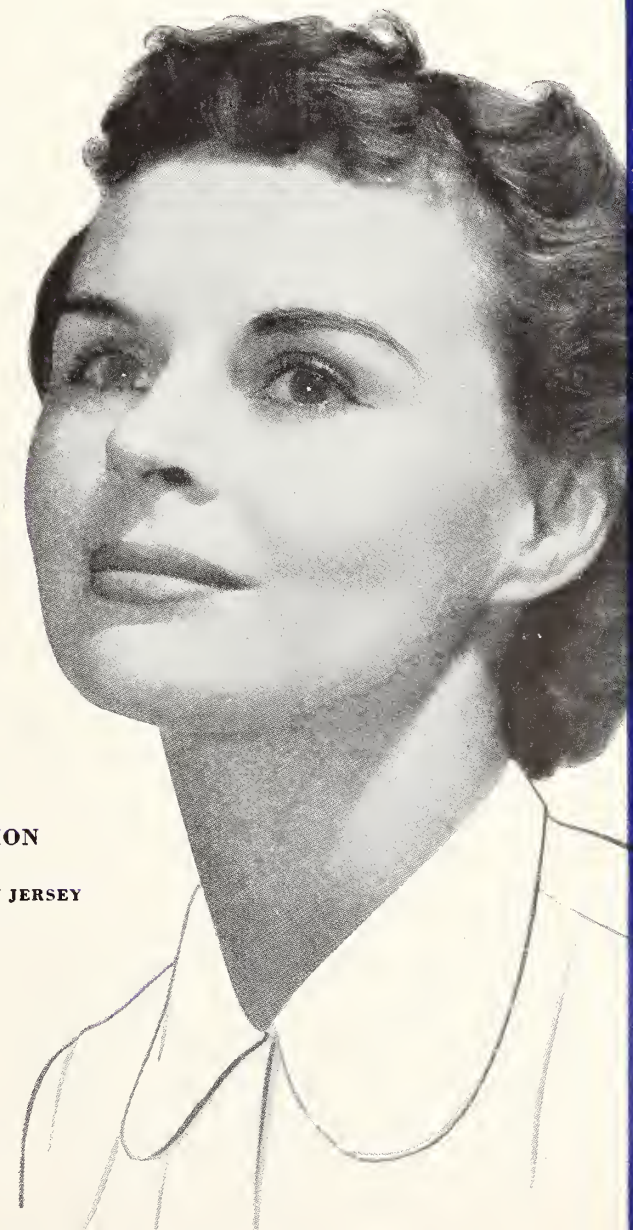
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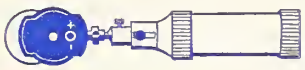
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THE JOURNAL

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PREVIEW OF ANNUAL SESSION

THE scientific program of the 102nd Annual Session will present a topflight program of the most timely and up-to-date subjects in medicine today.

On Tuesday and Wednesday, October 30 and 31, the State Association will be host to many authoritative speakers from out of state who will join with our own Hoosier authorities to put on an outstanding presentation.

The Committee on Scientific Work is to be congratulated for arranging a program of utmost interest, and one which will be of practical importance to every physician.

An entire afternoon will be devoted to a series of papers on ACTH and Cortisone. This will be followed by a round table discussion on the same subject. The caliber of the participants guarantees that all the reliable and solid information on these two hormones will be discussed.

Another afternoon is set aside for a thorough expose on the subject of fluid and electrolyte balance. Individual papers will be followed by a symposium which will be participated in by the speakers and others.

The American Medical Association will be represented at the meeting by two of its best speakers. The Director of Health Services of the Indiana Civil Defense Administration will speak on civil defense.

Examination of the program will show that the subjects of malignancy, hypertension, dermatitis, and deafness will be covered.

The complete program for the Annual Session will appear in the October issue. The scientific program follows:

TUESDAY, OCTOBER 30, 1951

9:10 a.m. **L. E. Burney, M.D.,** Indianapolis
"The Doctor's Role in Community Defense"

9:30 a.m. **James R. McVay, M.D.,** Kansas City, Missouri
"A Doctor Looks at Public Relations"

9:50 am., **George F. Lull, M.D.,** Chicago
"What the American Medical Association Is Doing with Your Dues"

10:20 a.m. **Joseph C. Bell, M.D.,** Louisville
"The Diagnosis of Malignant and Potentially Malignant Lesions of the Colon and Rectum"

11:15 a.m. **William M. Tuttle, M.D.,** Detroit
"The Mimicry of Carcinoma of the Lung"

11:40 a.m. **Carroll S. Wright, M.D.,** Philadelphia
"The Detection of Causes in Contact Dermatitis"

2:00 p.m. **General Subject:** *"Fluid and Electrolyte Balance"*
Khalil G. Wakim, M.D., Minneapolis-Rochester
"Physiological Basis"

2:30 p.m. **Frederic W. Taylor, M.D.,** Indianapolis
"Surgical Application"

2:50 p.m. **Walter F. Kammer, M.D.,** Muncie
"Medical Application"

3:40 p.m. **John A. Shively, M.D.,** South Bend
"Practical Application"

4:00 p.m. **Symposium** on *"Fluid and Electrolyte Balance"*
Moderator: **W. D. Gatch, M.D.,** Indianapolis
Participants: **Khalil G. Wakim, M.D.,** Rochester, Minnesota
Frederic W. Taylor, M.D., Indianapolis
Walter F. Kammer, M.D., Muncie
John A. Shively, M.D., South Bend

WEDNESDAY, OCTOBER 31, 1951

9:30 a.m. **Samuel R. Mercer, M.D.,** Fort Wayne
"Skin Cancer"

9:50 a.m **Edward G. Waters, M.D.,** Jersey City, New Jersey
"Medical and Surgical Treatment for Parturitional Hemorrhage"

10:15 a.m. **Geza deTakats, M.D.,** Chicago
"The Surgical Treatment of Hypertension"

11:10 a.m. **Hugh A. Kuhn, M.D.,** Hammond
"Allergy of the Ear and Deafness"

11:35 a.m. **Robert L. Patterson, M.D.,** Pittsburgh
"The Medical Preparation of a Patient for Anesthesia"

2:00 p.m. **General Theme:** *"Pituitary Adrenal Mechanism and Therapeutic Use of ACTH and Cortisone"*
Rachmiel Levine, M.D., Chicago
"The Physiological Effects of the ACTH-Adrenocortical System"

2:25 p.m. **William D. Robinson, M.D.,** Ann Arbor, Michigan
"Arthritis Aspect"

2:50 p.m. **Alan C. Woods, M.D.,** Baltimore
"Use of ACTH and Cortisone in Uveitis"

3:45 p.m. **Oliver C. Cope, M.D.,** Boston,
"Burns and Shock"

4:10 p.m. **Round Table Discussion:**
Moderator: **William D. Province, M.D.,** Franklin
Participants: **James S. Browning, M.D.,** Indianapolis
Joseph E. Coleman, M.D., Evansville
Rachmiel Levine, M.D., Chicago
William D. Robinson, M.D., Ann Arbor
Alan C. Woods, M.D., Baltimore
Oliver C. Cope, M.D., Boston

EXTRADURAL INTRASPINAL TUMOR OF THE CERVICOTHORACIC REGION WITH FEATURES SIMULATING MULTIPLE SCLEROSIS

WILLIAM R. CHAMBERS, M.D.

SOUTH BEND

ATAXIA, nystagmus, painless paraplegia, with remission and exacerbation, in a young subject, are among the generally accepted criteria of multiple sclerosis. When these evidences are supported by a negative myelogram of that level of the spinal canal, referable in the non-neurologist's mind to the lesion, the patient is sometimes permanently tagged and any future developments dismissed as a variant of the protean manifestations of the disease.

Many texts on neurology mention multiple sclerosis as one of the diseases requiring differential diagnosis from spinal cord tumor. Elsberg[1] states that such a problem occurs occasionally; Davidoff[2] declares it common. Almost all, however, infer that the diagnosis should not be difficult, because of the usual presence of increased protein in the spinal fluid, and positive evidence of block by Queckenstedt's test. Spinal fluid protein, however, in the case of extradural tumors, averages from 50 to 100 mg. only, according to Davidoff,[2] and it is well known that the protein content of fluid drawn from the lumbar area is apt to be lower, the higher (and more distant) the level of the tumor. Cervical tumors, therefore, may not show much increase. On the other hand, the Queckenstedt test, as it is sometimes done by an intern in a nonteaching center, with cursory, forcible, manual compression of the jugular veins, is apt to indicate only the most advanced subarachnoid block.

Meyer and Fine,[3] while describing cervical cord tumors simulating amyotrophic lateral sclerosis and posterolateral sclerosis, quote Neri[4] as having been misled into a diagnosis of multiple sclerosis by the presence of nystagmus associated with cervical spinal tumor. Brain[5] confirms the possibility of nystagmus occurring in spinal cord lesions, and attributes it "to a defect of afferent impulses from the cervical spine."

In a recent issue of the "Proceedings of the Staff Meetings of the Mayo Clinic," Bailey and Craig[6] describe a series of intraspinal meningiomas simulating degenerative diseases of the spinal cord, including multiple sclerosis. Case 2 in their paper presents some findings similar to the case herein described.

The following case illustrates some of the difficulties of diagnosis in an instance which, except for the alertness of the attending physicians, might have been neglected.

CASE REPORT

A thirty-two year old, slightly obese, fair, white female suffered a fall in August, 1949. Immediately thereafter she experienced difficulty in walking. She suffered no pain, but described her feet as feeling heavy and numb, more pronounced on the right. Her gait was staggering, and her speech was noticed to be slurred. Within a few weeks she began to suffer from constipation, and later from a tendency to urinary incontinence. In spite of medical care, the condition progressed, and she was finally hospitalized in November, 1949.

At this time a spastic paraplegia of the lower extremities was noted, more marked on the right. She had become completely unable to walk. Sensory loss was described as patchy, changing from one examination to the next, included vibration, pain, and temperature at approximately L-1. The deep tendon reflexes of the lower extremities were described as increased, and there was a Babinski on the right. A spinal tap was done, showing the fluid to be under normal pressure. The Wassermann was negative, the cells not remarkable, the gold curve within normal limits. The protein, however, was 220 mg. %. X-rays of the spine showed no erosion, no widening of the interpeduncular spaces. At first, when myelography was done, it was deemed necessary to run the pantopaque up to the low dorsal region only, since the lower extremities alone were involved. Myelography was reported negative. The fallacy here is apparent to any neurologist, as extramedullary tumors are often associated with a rising level of sensory loss, gradually climbing to the level of the lesion,[7] also, "Leg weakness is usually the first sign of motor involvement due to . . . tumors in the thoracic region (just) below the cervical cord level," according to Alpers.[8]

The patient was now seen by an orthopedist, who, wisely, was unsatisfied with the diagnosis, and neurosurgical consultation was called. At this time the patient again exhibited many signs suggestive of multiple sclerosis. Her attitude could now be interpreted as mildly euphoric, the mood perhaps attributable to a partial remission. She could again walk with assistance, and her bladder control was improved. Her speech was still slurred, and there was a sustained nystagmus on looking to the right. Otherwise her signs were confined to the lower extremities.

There was a marked ataxia of gait. Muscular weakness of both lower extremities was present,

Figure 1



much more marked on the right. The deep tendon reflexes were markedly exaggerated on the right, and ankle clonus and Babinski's sign were also present on this side. The superficial (abdominal) reflexes were absent. There was a definite sensory level to pin prick and cold on the left up to approximately L-1. Position and vibratory sense was poor in both lower extremities. Touch was slightly diminished on both sides up to about L-1. This, it was thought, constituted a modified Brown-Sequard syndrome. The upper extremities did not appear to be involved. A graded Queckenstedt's test was done now, for the first time, showing almost a complete block. A new myelogram was performed, running the pantopaque higher, and an intraspinal mass demonstrated, at D-1. (See Figure No. 1.)

The spinal fluid protein was now 600 mg. %. Just before operation, on December 16, 1949, a Horner's syndrome appeared on the right. It was only then, too, that a relative volunteered that the speech defect had existed since childhood.

At surgery, an extradural meningioma was found, wrapped three-quarters around the spinal cord, only the left lateral aspect remaining free. The tumor had insinuated itself on the right, into the root canals of C-7, C-8 and D-1. It was possible to remove it completely, along with a small section of the dura, to which it was attached. Two months later the patient had completely recovered except for a persistent Horner's syndrome.

In addition to the several features suggestive of multiple sclerosis, already discussed, there were a few other unusual findings. It is interesting to note that the onset was sudden, not gradual. The latter, Grinker[9] states, is more characteristic of spinal tumors. Also, in extradural tumors, according to Brain,[10] root pains not uncommonly occur early, while in this case they were absent.

SUMMARY

It is possible for spinal cord tumor, particularly in the cervical and high dorsal regions, to simulate closely other spinal diseases, among which is multiple sclerosis. A case is presented, characterized by evidence of euphoria and slurred speech, by nystagmus, painless paraplegia of sudden onset with remission, and what appeared at first to be a negative myelogram. An extradural meningioma at C-7—D-1 was found and removed, with almost complete recovery, two months after operation.

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USE OF RECTAL SUPPOSITORIES IN TREATMENT OF MIGRAINE HEADACHE*

MILTON L. BANKOFF, M.D.

MICHIGAN CITY

RECTAL administration of drugs is a time-honored method of pharmacotherapy which goes back to the dawn of antiquity. Egyptologists have reported on the use of drugs administered by this means as early as 1500 B.C.[1] However, in recent years such administration, being esthetically distasteful to many, is utilized usually as a last resort and has fallen into marked disfavor with practitioner and patient alike. The two main classes of drugs still given in fairly frequent dosage by rectum include:

1. *Stomach irritants*—Chiefly aminophylline and aminophylline compounds, because of pain of intramuscular injection and the frequency of gastric irritation following their use;
2. *Barbiturates*—Chiefly in pediatric practice, in those children averse to taking medication by mouth or with evidence of gastric irritation, Nembutal, Seconal, or other barbiturate compounds are frequently prescribed in suppository form.

It is our purpose in this paper to report on the successful utilization of a new suppository (E.C. 112)‡ in the treatment of migraine headaches and other chronic vascular cephalalgias in a group of 48 patients who had been unable to obtain adequate relief from ergotamine preparations (Cafergone) by mouth, and yet had been relieved by parenteral ergotamine in the form of Gynergen or DHE 45. These patients all preferred rectal administration to the use of self-administered hypodermic injections.

Many recent publications, including several from the group working at Columbia University,[2, 3, 4] have served to clarify our knowledge of the underlying pathophysiology of migraine, with the vasomotor imbalance theory by far the most popular. Proponents of the vascular theory believe that an initial vasoconstriction of the cerebral arteries produces visual and possibly other pre-headache phenomena prior to the onset of the headache. This prodromal period is then followed by distention of cranial arteries, primarily the external carotid and some of its branches. It is this arterial dilatation that is presumed to cause the headache.[4] The evidence that the headache of the migraine syndrome results from distention of cranial arteries is abundant. There is much to indicate that the distended branches of the external carotid artery both within and outside the cranium are chiefly involved, but probably any pain-sensitive artery of the head may participate in the production of headache.[10] There must be some, as yet unknown, basic factors which cause the dilatation and which alter the sensitivity of the blood vessel and its periarterial plexus. The relationship of migraine to endocrine equilibrium is likewise imperfectly understood, as is also the importance of psychological factors, and of allergy.[4, 5, 6, 7]

The criteria for the diagnosis of migraine headache are essentially based on the clinical history and include one or more of the following factors:

1) Temporary visual disorders preceding the headache, such as scintillating scotoma, photophobia, hemianopsia and blurred vision;
2) Recurrent throbbing headaches, usually unilateral at onset against a background of relative well-being;
3) Nausea, vomiting and irritability, occurring at the height of the attack;
4) History of migraine in the immediate family;
5) Personality characteristics of inflexibility and shyness in childhood, giving rise to adult perfectionism, rigidity and resentment, ambitiousness and efficiency. Certain individuals seem to have a constitutional predisposition which makes them prone to such sustained emotional states;
6) Less frequent symptoms such as paresthesias, speech disorders, dizziness, sweating and other vasomotor disorders;
7) Relief parenterally by ergotamine (Gynergen) or Dihydroergotamine (DHE 45), and relief by Cafergone in the great majority of cases.[3, 8]

In our group of patients, all had a history of migraine dating back to adolescence or earlier. The diagnosis was based on fulfillment of the above criteria, and particularly on the response to ergotamine or its derivatives.

Test Material—E.C. 112 is a rectal suppository containing 2 mgm. of ergotamine tartrate and 100 mgm. of caffeine in a cocoa butter base.

Test Group—In our series there were 48 patients, 36 females and 12 males, whose age varied from 16 to 65 years. The headache condition had been present from 2½ to 55 years. The types of headache may be tabulated as follows:

* From the Clinic Associates of Michigan City.

‡ The experimental suppositories, E.C. 112, used in this study were supplied by Sandoz Pharmaceuticals.

Type of Chronic Vascular Headache	Total No.	Male	Female	Average Duration of Symptoms
1. Histamine Cephalalgia	4	1	3	2 yrs.
2. Allergic	15	6	9	10 yrs.
3. Migraine (idiopathic)	19	3	16	18 yrs.
4. Tension	10	4	6	3 yrs.

Therapy—All patients, having first been treated with DHE 45 or with Gynergen to determine their response to ergotamine therapy, were given a package of six rectal inserts and instructed to insert one suppository in the rectum as soon as the prodromal period of a headache began. If possible, they were asked to lie down after the insertion of the suppository for one hour. If not, they were asked to restrict their activity to a minimum. All patients were then instructed to use a second suppository in one hour if not relieved. They were told to use no more than two suppositories for one attack and not to repeat treatment oftener than twice weekly.

Side Effects—No patient complained of rectal irritation, pruritus or pain. None noted nausea, vomiting, or peripheral vascular changes. Most interesting to us, in view of the frequency of side-effects by other routes, was the complete absence of any untoward reactions in the use of these suppositories. In no instance did the suppository produce any ill effects.

Results—Of the 48 patients tested over a period of eight months, 38 reported good to excellent results with the use of the rectal suppositories when used early in the attack. This represents a total of 79 percent positive responses, higher than other reports to date.[4, 9] Our explanation of this fact lies in the following theories:

1. All patients were very cooperative in using suppositories at the onset of the attack;
2. Simple psychotherapeutic therapy accompanied the presentation to the patient of the package of suppositories.

Type of Chronic Vascular Headache	No. of Patients	Excellent* Response	Good** Response	Poor*** Response
1. Histamine cephalalgia	4	2	1	1
2. Allergic	15	9	4	2
3. Migraine (idiopathic)	19	13	3	3
4. Tension	10	2	4	4
Total	48	26	12	10

* Complete relief of symptoms

** Partial relief of severity and duration of symptoms

*** Little or no relief of symptoms

Failures—Reevaluation of failures by use of this method led to the following findings:

1. Three of the patients in the "poor" category were neurotic. There is some question in our minds as to the exact nature of their headache, and whether it might not be better classified as a conversion hysteria. These patients fall in the tension headache group.

2. The patient with histamine cephalalgia who had poor results responded well to routine histamine desensitization therapy, using 2.75 mgm. of histamine diphosphate (Lilly) intravenously.

3. The patients with allergic headaches who reported poor results are doing well on elimination diets, and no exacerbations have been noted in the past four months.

4. Those patients with true (idiopathic) migraine who did not respond must be classified as simply resistant to rectal therapy since, as stated above, in every case they had previously responded well to hypodermic ergotamine tartrate or its equivalent.

Comment—The advantages of rectal suppository administration in the patient resistant to oral medication are two-fold:

1. Added convenience—In almost any occupation, anywhere the patient may go, he can take two suppositories with him. They require none of the paraphernalia necessary to maintain the sterility required for parenteral injections and require no special technique for their use. For this reason, patients who show no response to the oral Cafergone can use the rectal insert at the very onset of the headache—the time agreed upon by all clinicians for the optimum effect;

2. Rapidity of action—In our series, most patients reported relief in 30 minutes. This compares favorably with oral medication, although appreciably slower than hypodermic injection.

It is important in discussing this problem with patients to remind them that ergotamine therapy, whatever the form, is symptomatic therapy alone—and therefore no more curative than antihistamines for hay fever. Then, just as specific desensitization will in many cases prevent hay fever, so psychotherapy will in many cases prevent recurrent migraine attacks. A few patients, as mentioned above, can be cured of their particular type of headache by specific treatment (e.g., elimination diets, histamine desensitization, etc.) but the vast majority of migraine sufferers will benefit most by therapy along psychiatric lines.

Personality studies and interviews will permit the general practitioner to identify various personality factors which make the patient vulnerable to attacks of migraine. The physician can then help the individual to understand the salient facts which are the basis of his problem and which result in tension. Ample opportunity should be allowed the

patient to discuss his emotional problems. In the migraine patient these are essentially resentment and frustration. Advice may be given concerning change in attitudes and habits and the avoidance of unhealthy environmental situations.

After the migraine patient understands the setting of the attacks, he should strive for a modification of his daily program. It is often advisable to have the patient work up to three-fourths of his capacity, and take adequate periods of rest and relaxation. Sometimes the use of small doses of barbiturate and sedative tub-baths will facilitate the patient's change of pace during the period of reorientation and adjustment. The emotional problems and efforts towards readjustment cannot be overemphasized in the successful treatment of migraine. Only through an understanding of emotional reactions and attitudes can we hope to relieve the frequency and severity of these distressing attacks.[3, 8]

SUMMARY

Trial of a new rectal suppository (E.C. 112), containing 2 mgm. ergotamine tartrate and 100 mgm. caffeine, in the treatment of vascular headache is reported. Seventy-nine percent of a group of 48 patients who had previously responded well to hypodermic Gynergen or DHE 45 reported good to excellent results with the use of rectal inserts at the onset of each attack over a trial period of eight months.

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The Indiana Academy of General Practice has arranged to give credit to its members for their attendance at classes of the Instructional Courses to be given October 29, 1951, at the annual session of the Indiana State Medical Association. These courses are outlined in this issue of THE JOURNAL and the order blank for the reservation of tickets for attendance at the courses is on the same page. Members of the Indiana Academy of General Practice should enter their orders promptly for such courses as are desired.

HYPOADRENALISM IN NEWBORN INFANTS†

A Case Report

BRUCE F. GROTTS, M.D.††

MICHIGAN CITY

IT IS NECESSARY to consider the possibility of temporary hypofunction of the adrenal glands in newborn infants who reveal protracted gastro-intestinal disturbances, a failure to gain weight on adequate caloric intake, an unexpected tendency to dehydration, and an unsatisfactory response to accepted treatment measures.[1] Until recently such a symptom-complex has often been overlooked and treated as a difficult feeding problem.

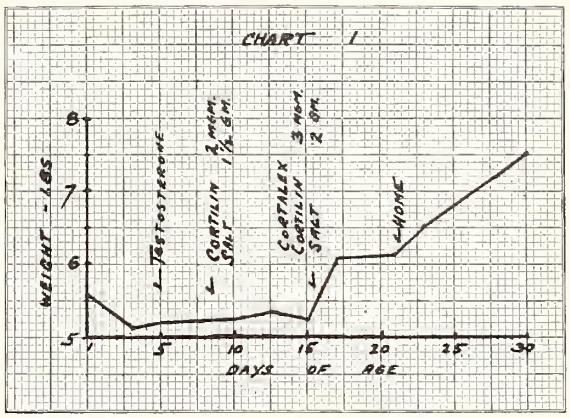
The following case is the history of such an infant who revealed marked improvement following temporary adrenal replacement therapy.

CASE REPORT

After a normal birth and prenatal history, baby L. F. was born, weighing five pounds nine ounces. He appeared normal at birth and was placed on a standard dilution Similac formula. Weight dropped about eight ounces in the first three days to five pounds one ounce, and he did not nurse well on Similac. Since the weight now was considered at the premature weight level (less than 2500 grams) and it is felt that prematures do not tolerate fat well, he was placed on a low fat formula (Dryco) and given oral testosterone to try and increase the nitrogen balance and stimulate his sucking reflex. Zymatinic drops were also started.

Because his color was greyish, and he had an occasional cyanotic episode, a chest x-ray was taken, but it revealed no cardiac or mediastinal abnormalities. He did not gain weight despite adequate caloric intake. The difficult feeding became worse and he finally refused to suck. His temperature remained 98 degrees rectally. Gavage feedings were initiated and clyses were continued in order to keep him hydrated. He tended to become dehydrated easily, and the grey color persisted.

On the eighth hospital day he was started on a synthetic adrenal cortex preparation (Cortilin),* two mgm. daily (see Chart 1.). One and one-half grams of salt were added to the Dryco formula. Greenish loose bowel movements had been present and continued, as well as the hydrolability. For the next eight days his weight remained constant and nursing remained poor, although somewhat improved. Gavage was continued. Lethargy and anorexia persisted despite several transfusions. He seemed to tire of sucking before getting enough food, and vomiting after meals was a problem.



The blood count prior to transfusion was slightly low (twelve grams of hemoglobin per 100 cc.), but returned to normal thereafter. Stool study for pancreatic enzymes showed normal tryptic activity.

On the sixteenth hospital day the Cortilin was increased to three mgm. daily, Cortalex** tablets (Natural adrenal cortex steroids) by mouth were started and the salt was increased to two grams daily. Immediately thereafter weight gain was rapid, the stools became normal, hydration became good, color improved, and he began to suck on the nipple, cry, and move about.

He has continued to gain weight after leaving the hospital and at last check he was only ten ounces below the average infant's weight. Cortalex and salt were continued for three weeks after termination of hospitalization and then were discontinued. He has shown steady improvement and his length has increased two and one-quarter inches as compared to one and one-half inches in the average infant over the same period of time.

DISCUSSION

Normally, the fetal adrenal cortex regresses at term and changes to the adult type. The fetal or androgenic zone atrophies until only a few cells persist, which in turn develop into the adult reticular zone.[2] In those cases of adrenal insufficiency in infancy going to autopsy there has been a persistence of the "fetal" cortex interfering with the zona glomerulosa, androgenic hyperplasia with macrogenitosomia, or adrenal hemorrhages, encapsulated hematomas, or cysts.[2,3,4] The incidence of proven cases of adrenal insufficiency, however, is very low.[5] It seems probable, then, that failure of regression or temporary arrest of this process

† Read before the Staff of St. Anthony's Hospital, Oct. 1950.

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* Lincoln Laboratories, Decatur, Illinois.

** Upjohn Co., Kalamazoo, Michigan.

during the transition period could cause a temporary hypoadrenia.[6]

Such hypoadrenalism would explain many of the symptoms and signs noted in these infants. A consideration of some of the known functions of the adrenal cortex is essential for the interpretation of these signs. Three of the better known functions are retention of salt and water and excretion of potassium by the kidney through hormones related to 11-desoxycorticosterone, gluconeogenesis through the S (sugar) hormones, and anabolism and nitrogen retention by way of the N (nitrogen) hormones. With a decrease of these factors it is to be expected that these infants would reveal hydrolability and a tendency to gastrointestinal upsets, lassitude, disturbances in carbohydrate metabolism, as well as disturbances in growth.

The case reported is similar to one reported recently by Moore and Cermak.[3] Their case was a normal appearing infant at birth who failed to gain weight and had a tendency to loose bowel movements and easy dehydration despite adequate fluid intake. Their infant also had a grey color and was markedly lethargic. Vomiting was present. Studies of his stool and chest were normal. His condition grew progressively worse despite apparent adequate treatment and desoxycorticosterone acetate therapy. It was only when DOCA was increased to two and then three mgm. daily with two grams of salt that results became dramatic.

Jaudon[1] collected a series of five infants, all male, as was the one of Moore and Cermak[3] and the one reported here. Anorexia and regurgitation and vomiting were present to some degree in the neonatal period and weight loss was out of proportion to the amount of food regurgitated. During periods of dehydration excessive amounts of dilute urine high in chlorides was passed. During periods of treatment urinary volume and chlorides were normal. Consistent laboratory findings before treatment were moderate reduction of carbon-dioxide combining power, moderate elevation of blood NPN, and normal to low serum chlorides.

Adequate treatment during the regulatory period consisted of two grams of sodium chloride daily and two to three mgm. of desoxycorticosterone acetate daily.[1,7]

SUMMARY AND CONCLUSIONS

It would seem that any newborn infant considered a feeding problem but revealing rapid weight loss, asthenia, a peculiar grey color, and tendencies toward dehydration and gastrointestinal upsets (vomiting or diarrhea) might deserve a therapeutic test, since the symptoms and signs noted suggest hypofunction of the adrenals; and functional adrenal insufficiency, according to Selye,[4] may be a common but unrecognized clinical problem. In the experience of Geppert, et al.,[7] about one in every one thousand newborn infants demonstrates evidence of adrenal insufficiency sufficient to warrant empirical administration of cortical extracts and the addition of salt to the diet; a treatment which is apparently a safe procedure as no untoward reactions have been noted in the literature reviewed.

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The schedule of courses and the order blank for tickets for the Instructional Courses is on page 859 of this issue.

INTUSSUSCEPTION IN THE ADULT

S. D. Malouf, M.D.

PERU

DURING the lifetime of the average surgeon intussusception in the adult is met with only occasionally and it is unusual to find in the literature reports of large series of cases. This fact has prompted a review of the literature, with a case report.

CASE REPORT

H. S., a white woman aged 38, was admitted to the Miami County Hospital June 7, 1947, because of intermittent cramp-like pains over the left colon. X-ray studies by means of barium enema revealed that the colon filled without obstruction. The descending colon was tube-like. The haustral markings were few in number. The gross pathology was interpreted as colitis. She was discharged three days after admission.

On July 25, 1947, she reentered the hospital, complaining of weakness, nervousness and cramp-like pains over the left colon and the periumbilical region. On the night of July 30, she was seized by sudden excruciating pain over the same area, accompanied by several dark brown emeses. Her temperature was 97° F., pulse 120 and weak. During her stay in the hospital she took little nourishment but her bowels moved daily, with a small, well-formed stool. The blood examination showed erythrocytes 4,320,000, leukocytes 8,300, in each cubic millimeter. The urine was normal. She was treated conservatively and dismissed August 4, 1947, slightly improved.

A month later she entered another hospital in a large city under the care of a prominent internist. Complete physical, laboratory and x-ray studies were made, and the final diagnosis was small multiple ulcerations involving the small intestine. She was sent home with special instructions regarding diet, medication and rest. She followed this regimen faithfully for two months with little benefit. In despair, she finally drifted to an osteopathic physician who likewise treated her for over four months, with the same result.

On March 14, 1948, she was admitted to the Miami County Hospital under my care, complaining of "stomach trouble" and pain in the abdomen which was intermittent, cramp-like in character over the periumbilical region, and radiated to the back.

On several occasions borborygmus and passage of flatus accompanied the attack and seemed to relieve the cramps for the moment. These symptoms increased in frequency and severity up to the time of admission to the hospital. The pains had no relation to meals and were not relieved by alkalies or food. At no time did the patient notice any blood in the stools or diarrhea. Previous to her illness she weighed 190 pounds; on admission her weight was 130 pounds. Personal and family histories were not contributory.

On examination, the patient was a well-developed and fairly well-nourished middle-aged woman, whose temperature, pulse and blood pressure were within normal limits. The head, neck, heart and lungs were essentially normal.

Examination of the abdomen revealed a large elongated tumor mass over the right side of the colon extending to and above the umbilicus. The mass was soft, movable and slightly tender on pressure. The liver and spleen were not palpable. There was no fluid wave or dullness in the flanks. The external genitalia were normal in appearance and on pelvic examination the cervix and uterus were in good position, the fundus was normal in size and there were no adnexal masses. No mass or stricture was felt on rectal examination and there were no hemorrhoids.

All the tendon reflexes were present and normally active and no disturbance of sensation was noticed.

The urine was normal. The concentration of hemoglobin was 70 percent (Sahli), the erythrocytes were 3,200,000 and the leukocytes 8,150 in each cubic millimeter of blood. The differential count was within normal limits. The Mazzini test for syphilis was negative. The stool was semisolid, of normal color and there were moderate amounts of mucus, leukocytes and erythrocytes. A flat plate of the abdomen showed gas pockets in the mid-epigastrium. A barium enema failed to go further than the mid-transverse colon. The x-ray diagnosis was a partial obstruction in the mid-portion of the colon. It was the opinion of the radiologist that the obstruction was caused by a tumor, probably malignant.

Several pathologic entities, including intussusception, were considered in the differential diagnosis.

She was given daily enemas for three days. These returned clear with a moderate amount of flatus and mucus. She was given blood and parenteral infusions and concentrated vitamins. In view of the history and x-ray findings surgical exploration was decided upon.

On March 17 the abdomen was opened through an upper right rectus incision, revealing a large mass involving the cecum and ascending colon. The mass was easily brought out through the in-

cision and examined very carefully. On further inspection the cecum and appendix were found missing, and tracing the ileum it was found that the lower ileum, cecum and part of the ascending colon were intussuscepted into the distal part of the ascending colon. The intussuscipiens had lost all of its luster and showed a marked hypertrophy. The apex of the intussusceptum was at about the hepatic flexure. On palpation it gave the impression of a tumor mass. There was a slight degree of edema and congestion of the mesentery of the ascending colon and a small amount of serous fluid present in the abdominal cavity.

Because of the induration and apparent lack of viability of the cecum and ascending colon, it was deemed advisable to remove this portion of the bowel including the lower ileum. A one-stage primary resection and anastomosis was carried out. The cecum, ascending colon and a part of the ileum were removed in one block. An ileocolostomy of the end-to-lateral type of anastomosis between the ileum and transverse colon was then performed and the rent in the mesentery sutured. Part of the omentum was sutured to the anastomosis, sulfanilamide crystals were dusted over the operative field and the wound closed in layers without drainage.

The specimen was sent to the South Bend Medical Foundation laboratory and was reported on as follows:

"Gross appearance: The mass consists of a segment of colon which is greatly dilated, measuring approximately 8 cm. in diameter. On opening the specimen it is seen that the colon is telescoped into its own interior. There is a necrotic mass of indurated tissue which may represent tumor tissue or a polyp which has incited the condition. The segment which is telescoped is remarkably edematous and there are cystic areas in this segment of the bowel wall which probably represent areas of accumulations of lymph, the return flow of which has been obstructed as a result of the intussusception.

"Microscopic examination of section through the necrotic head of the portion of the colon which is the site of the intussusception shows only necrotic mucosa with granulation tissue replacement of the mucosa. There is no evidence of malignancy. Section through the cystic areas described grossly show a loose edematous type of connective tissue which in some respects resembles ovarian connective tissue. It is thought possible that this may be an explanation of the intussusception, namely, that there has been some congenital malformation here, possibly a dysontogenetic type of new growth and that this stimulated the formation of an intussusception. The segment of the bowel leading into the intussusception is identified microscopically as ileum. There is nowhere evidence of malignant disease.

"Pathological diagnosis: Intussusception of ileum into ascending colon."

The patient's recovery was uneventful and she was discharged in the third week with a good functioning anastomosis.

HISTORICAL REVIEW

As early as 300 to 350 B.C. intussusception was recognized by Hippocrates who treated it by inflating the bowel from below. In the 16th Century it was confused with volvulus and was separated from it by Peyer in 1667. In 1700 Bonetus[1] reported the first operation for intussusception. The second recorded case was reported in 1751 by Velse.[2]

A review of the literature for the past sixty years reveals mostly cases in children under two years of age. Hinton[3] stated that 95 percent of all acute cases occurred in children. According to Sullivan,[4] it is almost the only cause of obstruction in infants. Intussusception occurs in either the acute or chronic form. The acute variety is by far the more common in infants, and the chronic type is met with more frequently in adults. In a report of 30 cases of chronic intussusception, Mayo and Phillips[5] encountered one case in a patient only ten years of age. Out of 113,351 patients admitted to St. Luke's and St. Mary's Hospitals, F. B. Davis[6] found intussusception in only 22 instances and only one patient was an adult, twenty-four years of age. In the report of Botsford and Newton[7] only five adults with intussusception were admitted to the Peter Bent Brigham Hospital in Boston between 1913 and 1940.

CLASSIFICATION OF INTUSSUSCEPTION

In the common type of intussusception the invaginated loop consists of two layers, an afferent and an efferent, forming the intussusceptum. The distal loop forms a single ensheathing layer and is called the intussuscipiens. In the average case the mechanics of intussusception are governed by the presence of material within the lumen of the normal intestine, be it tumor, ulcer, foreign bodies, or edematous mucosa. According to Wordell, these act as foreign bodies within the lumen of the gut and produce spasmodic contraction of the proximal segment and inhibition with dilatation of the distal segment; thus the contracted portion containing the lesion may enter the dilated portion and isoperistaltic intussusception results. Invagination may occur in any portion of the gastro-intestinal tract and it is usually the upper segment that passes into the lower segment. Retrograde intussusception is one in which the foregoing may be reversed. The presence or absence of a mesentery in the ascending colon, cecum and terminal ileum play a major part in the progress of ileocecal and ileocolic intussusception. With a long mesentery the ileocecal and the ileocolic types of intussusception ascend high up, and when there is no mesentery the process usually stops at the ileocecal valve. The mobility of the cecum and the undue length

of mesocolon present potentially favorable conditions for the invagination to occur.

Anatomically, intussusception may be classified as (1) enteric, in which the small intestine invaginates a portion of itself; (2) colic, in which a portion of the large bowel invaginates into a more distal portion; and (3) enterocolic, which may be subdivided into (a) the ileocecal, in which the ileum and the ileocecal valve invaginate into the cecum; and (b) the ileocolic, in which the ileum alone passes through the ileocecal valve.

ETIOLOGY

In the adult type it is quite common to find a causative factor, while in the infantile type it is idiopathic. The history in the adult suggests that the invagination has been present several times, reducing itself and being succeeded by a period of quiescence, before the symptoms were sufficiently acute to force the patient to enter the hospital. In 122 such cases collected from the literature by Goodall,[8] the condition had been present for more than six months in 32 cases and for more than one year in 11.

The most frequent causes of intussusception in the adult are (1) intestinal tumors, either benign or malignant; (2) intestinal ulceration; and (3) diverticulum. Christopher,[9] in a twenty-five year period, collected 59 cases of adult intussusception, of which 43 were due to benign tumors and 16 to malignant tumors.

Trauma as a causative factor is rarely referred to in the literature. Martin and Love[10] reported one case following injury and recorded four similar cases.

In the classical analysis of 300 cases of intussusception in the adult by Eliot and Corscaden[11] in 1911, one-third of this series was due to tumors, 40 percent of which were malignant and 60 percent benign.

Bolker and Hamilton,[12] in 1943, reported a case in an adult due to tuberculosis. Chaffin[13] reported one case of intussusception during pregnancy and collected 11 cases from the literature since 1870.

In 1941, H. G. Nichols[14] reported intussusception in the adult associated with tumor, diverticulum or an ulcer in 70 percent of cases. Congenital malformation, possibly a dysontogenetic new growth, has not been recorded in the literature as a possible etiological factor in intussusception in the adult. The case here presented is an example of such a lesion. Multiple intussusceptions are rarely found during life but a number have been reported in postmortem examinations, especially of the small intestine.

Intussusception in the adult is a relatively uncommon condition. Five to 10 percent of all cases of intussusception occur in the adult.

SYMPTOMS

There are no cardinal symptoms of intussusception in the adult, since a large number of cases follow a chronic course which may simulate several intra-abdominal lesions. The classical picture of acute intussusception in the adult is that of acute intestinal obstruction and not always associated with a palpable mass. Blood in the stools and a palpable mass by rectum are not constant and are far less frequent in adults than in children. Mere invagination of the bowel need not lead to strangulation or complete obstruction. It is the extent of the circulatory disturbance of the engaged portion of the mesentery resulting in venous stasis, exudation, infection and finally gangrene. In the chronic type, the symptoms usually extend over weeks and months with a history of recurrent attacks of colicky pains in the abdomen, vague in character, and occasionally nausea and vomiting may accompany the attack. Such were the character and progress of the symptoms in the case here reported.

In many cases the intussusception is without symptoms, particularly if the tumor is small and the invagination nonobstructive. Larger tumors are more apt to be obstructive and productive of symptoms. The condition may be fully obstructive at some stage of the development and the symptoms may become so acute as to demand prompt intervention. It may be mistaken for other intra-abdominal disorders, such as perforating ulcer, cholecystitis or appendicitis. Constipation is a prominent symptom often alternating with diarrhea. Bloody stool and diarrhea were absent in the case here reported. The abdomen is not distended until or unless obstruction becomes a pronounced feature, and then nausea and vomiting enter the picture. Examination of the abdomen may disclose local tenderness and spasticity, either with or without a palpable tumor mass. Inasmuch as intussusception is a strangulation obstruction, it is to be noted that this form may occur without local tenderness or muscle spasm due to the fact that the strangulated segment, the intussusceptum, is enclosed within the intussuscipiens and produces no irritation of the parietal peritoneum.

DIAGNOSIS

The diagnosis of intussusception in the adult is more difficult than in early infancy and it is not easily differentiated from other forms of intestinal obstruction. The fact that in the adult obstruction caused by intussusception is incomplete explains why in many the diagnosis is difficult and the mortality is high. When a palpable tumor mass is absent the differential diagnosis is extremely difficult. If the abdomen is examined during a colicky recurrence of pain a peristaltic tumor may be found which disappears with the subsidence of the pain. Auscultation may reveal peristaltic sounds. Final conclusions are often

reached by employing the x-ray. A flat plate of the abdomen and barium enema are of inestimable value.

G. T. Pack[15] called attention to the following observation as an aid in the diagnosis: "In cases of obscure abdominal pain occurring intermittently for a long time, with intervening episodes of complete freedom from pain, with signs and symptoms of transitory obstruction associated with a palpable mass, especially if in the right half of the colon, a tentative diagnosis of intussusception due to benign tumor is in order."

Repeated roentgenographic examination of the colon in the case here reported did not demonstrate intussusception. The interpretation of the last colon study by the roentgenologist just before operation was obstruction to the passage of barium with no definite evidence suggesting intussusception. The roentgenograms, however, are of value because they localize the lesion for subsequent surgery.

TREATMENT

Once the diagnosis is established the treatment is entirely surgical. The dangers of procrastination are as great in the adult as they are in children.

The therapeutic approach to this problem involves the following considerations: (1) Reduction in order to relieve the obstruction and the circulatory impairment. (2) Correction of possible etiological factors. A survey of the literature reveals conservative therapy, such as the use of hydrostatic pressure to effect reduction of the invagination, is still utilized by some men. In the adult it is much better to regard intussusception as a strictly surgical condition and to resort to operation as soon as the diagnosis is made. Obviously, the use of hydrostatic pressure does not permit the removal of a tumor, diverticulum or the recognition of an unviable bowel.

Enemas are more appropriately applied in the treatment of the condition in infants and children.

Critical analysis in the literature of intussusception in the adult tends to show that the disadvantages in the use of barium enema as a method of reduction far outweighs the advantages. Reduction may be accomplished by manipulation through an abdominal incision. A trial by manual pressure over the apex of the intussusception with light traction on the proximal free bowel is justifiable in cases where extensive edema and impairment of the circulation is either absent or present in a small degree, otherwise a tearing of the bowel or mesentery may result. Some cases may present no difficulty in manual reduction even in the presence of hemorrhage into the wall of the bowel, with slight edema and plastic exudate. However, in these cases resection is the operation of choice, otherwise the above-mentioned pathologic changes may result in the formation of scar tissue, with fibrous stenosis, kinking or simple stricture. These changes often result in obstruction at a later date and may require short circuiting operations or resections of the involved segment of bowel.

In the managment of irreducible intussusception the surgeon is faced with a problem relative to the type of technical procedure which will result in a relatively lower mortality and morbidity.

Brown[16] advocates incision of the neck of the invagination on the antimesenteric side of the bowel. This will frequently release the incarcerated segment which may then be drawn out. The incision is closed with a double row of sutures.

In 1921 Kingsford[17] reported a case of intussusception in an adult in which the ileum was anastomosed to the transverse colon because the intussusception was irreducible. Ten days after operation the entire necrotic intussusception was passed and the patient recovered.

In the final analysis resection seems to be the method of choice and here the surgeon must decide between a one- or two-stage procedure.

In view of the high mortality of resection with immediate anastomosis in the presence of acute obstruction, resection of the obstructed portion of the bowel by an exteriorization operation would seem in general to be the logical procedure. There is a clear connection between the duration of symptoms and mortality. One of the most important considerations in the reduction of morbidity and mortality observed in recent years has been the improvement in pre- and postoperative treatment, the control of shock, toxemia and dehydration. The use of parenteral fluids, blood transfusions, antibiotics pre- and postoperatively are well established.

In the cases complicated by mild localized peritonitis and edema of the mesentery, primary resection with primary anastomosis, with or without ileostomy or colostomy, is feasible. The early experiences with this method were discouraging. Billroth's mortality was 60 percent. The exteriorization method popularized by von Mikulicz reduced the mortality to 16.6 percent in the cases he reported. The multiple stage exteriorization operation is now considered by some surgeons to be the operation of choice. Despite its advantages, the method presents definite disadvantages. Multiple operations mean multiple risks, high incidence of complications, such as wound disruption, wound infection, persistent fistulas and postoperative hernias. Convalescence and hospitalization are prolonged. The sole argument of low mortality for this method has been challenged recently by reports of a number of surgeons who have been performing the one-stage resection with primary anastomosis. The striking improvement with the one-stage method is due not so much to the refinements in the technic of bowel anastomosis as to

the recent advances in the pre- and postoperative care of the patient. The dangers incident to a primary resection and anastomosis of the bowel are not as imposing now as in the past. The use of whole blood transfusions, antibiotics and sulfonamide compounds has to a considerable extent eliminated shock, hemorrhage and infection as a cause of death. The use of parenteral fluids for hydration and nutrition and the use of intestinal intubation for decompression have also improved the patient's prospects for recovery.

The consensus seems to be that the one-stage resection is a safe procedure, and this proved to be true in the case presented. It must be understood that primary resection and anastomosis in one stage is not recommended or advisable in cases of intussusception associated with acute obstruction of long duration or advanced inflammatory peritoneal invasion.

SUMMARY

1. A case of chronic intussusception in an adult woman due to dysontogenetic type of new growth is reported.

2. The literature on intussusception in the adult is reviewed.

3. Intussusception in the adult is a chronic and relatively uncommon condition.

4. Mention has been made of the classification of intussusception, including the relatively uncommon retrograde type of intussusception which has been reported recently.

5. The probable etiological factors and mechanics of intussusception have been reviewed.

6. The symptoms of intussusception in the adult are vague and extend over weeks and months, and usually are mistaken for other intro-abdominal lesions, hence the diagnosis of intussusception in the adult as compared with the same condition in early infancy is more difficult.

7. The treatment is entirely surgical; the dangers of procrastination are as great in the adult as they are in children.

8. In the reported case a one-stage primary resection with anastomosis was done, with recovery and good functioning anastomosis.

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The Instructional Courses of the 1951 Session will present discussions of "Pediatric Problems," "Salt Metabolism in Congestive Heart Failure and Hypertension," "Impotence and Infertility," and "The Headache Problem."

COLD URTICARIA

H. Harold Rodin, M.D.

SOUTH BEND

AND

Samuel M. Bluefarb, M.D.

CHICAGO

THE following case report is being presented because of the presence of cold urticaria in a child. This was one of twenty-one cases of cold urticaria occurring in four generations of a family.

According to Urbach, Herrman and Gottlieb,[1] hypersensitiveness to cold is not invariably allergic, i.e., based on an antigen-antibody reaction. They state that hypersensitiveness to cold can be brought on in a variety of ways:

(a) Allergically, with the physical agent acting as antigen.

(b) By autoantigens produced in the tissues under the influence of physical forces.

(c) By histamine-like substances released in the tissues under the influence of physical irritation.

(d) Frequently and unquestionably as the expression of an underlying vasomotor neuropathy.

(e) Occasionally, perhaps, by disturbances in the central temperature-regulating mechanism.

They considered their case as a hypersensitiveness to cold, based on a nonallergic mechanism and designated the condition as "cold pathergy." A similar case has been reported by Kile and Rusk.[2] A case of cold urticaria with general symptoms of more than twenty years' duration was described by Rajka and Asboth.[3] In this case the urticarial reaction appeared not only locally but followed the lymphatics. Despite negative passive transfer tests they considered their case as an allergic one, in which antibodies were firmly bound to the cell, and not merely the direct result of cold.

LABORATORY FINDINGS

HEMOGRAM:

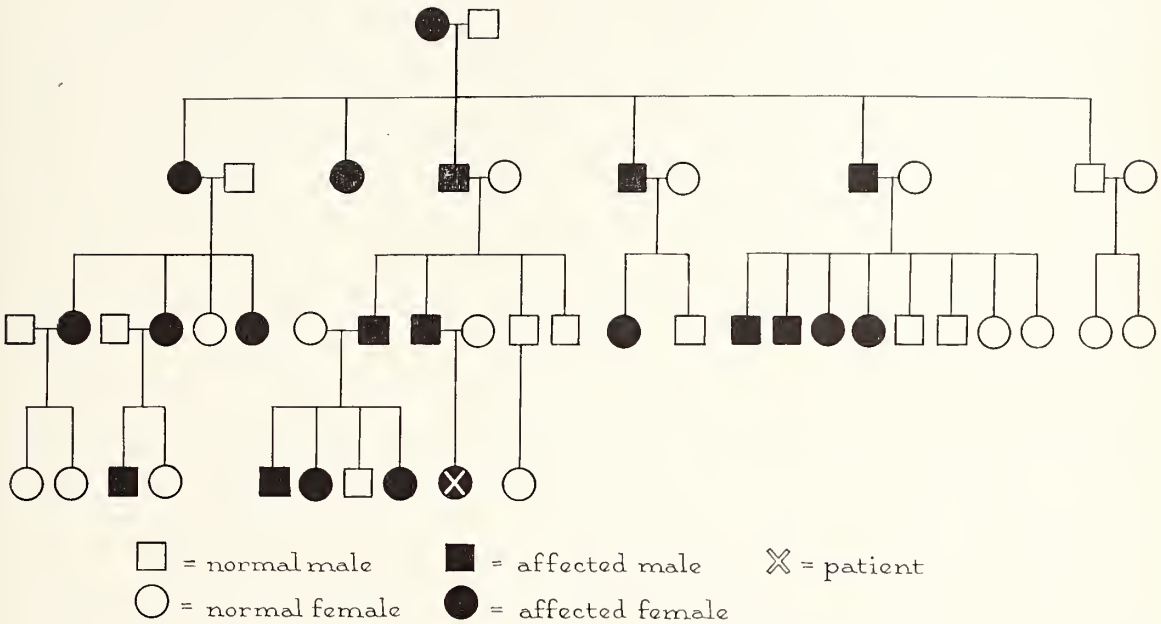
Date:	1-5-49	4-13-49	7-8-49	11-18-49
Hemoglobin, percent	74.6	68	76	88
Red Blood Cells, per. cu. mm.	3,930,000	4,120,000	4,860,000	4,290,000
White Blood Cells, per. cu. mm.	9,800	23,000	12,450	9,400
Polymorphonuclears, percent	52	70	56	55
Lymphocytes, percent	38	21	37	26
Eosinopbils, percent	4	1	3	3
Monocytes, percent	6	8	4	9
Band Forms, percent				7
Platelets				415,000
Reticulocytes, percent				0.89

URINALYSIS:

Date:	11-1-49 (Eruption Present)	11-2-49 (Eruption Terminated)
Reaction	Alkaline	Acid
Albumin	Negative	Negative
Sugar	Negative	Negative
Microscopic	Several pus cells	Several pus cells

Porphyrin Screening Test (Wood Filter)	negative	Warm Agglutinations	negative
Cryoglobulin	negative	Cold Agglutinations, 1:4 Dilution	insignificant
Coomb's Test	negative	Fragility Test	normal
		Passive Transfer Test	negative

GENEALOGIC CHART SHOWING 21 CASES of HYPERSENSITIVENESS to COLD in FOUR GENERATIONS



The case reported here was unusual in that the eruption appeared shortly after birth and there was involvement of twenty-one members of the family in the course of four generations.

REPORT OF CASE

D. W., a 4½-year-old, white girl, was a full term normal infant. The mother stated that shortly after birth the child presented a mild skin eruption consisting of scattered "red spots." It was later noted that these lesions occurred only after exposure to cold, one-half hour being the usual time of exposure necessary to provoke an attack. Termination of the eruption resulted in one hour by covering the child with several blankets.

The past history was essentially negative, the child having had none of the usual childhood diseases. The family history revealed this condition to be present in twenty-one members.

On examination of the skin there were numerous edematous papules and urticarial lesions present on the cheeks, neck and exposed parts of the upper and lower extremities. The eruption was not pruritic.

Physical examination revealed a grade II systolic murmur over the apex of the heart. The liver was palpable two centimeters below the costal margin and the spleen palpable one centimeter below the costal margin. There was profuse perspiration.

The father of the patient is affected with a similar condition. He stated that his constitutional symptoms, consisting of profuse perspiration, headache, nausea, abdominal cramps and joint pains, associated with the termination of the attack, did not occur until he had reached the age of 16 or 17 years.

The onset of these symptoms at approximately the same age is characteristic for other members of the family. The presence of this condition in twenty-one members of the family in four generations (Figure 1) would indicate the dermatoses to be a dominant, non-sex-linked Mendelian trait.

SUMMARY

1. A case of cold urticaria is reported in a 4½-year-old girl. The child is one of twenty-one cases of cold urticaria occurring in the family within four generations.

2. All laboratory tests, including passive transfer tests, cold agglutinations, cryoglobulin and Coombs test, were essentially negative.

3. The presence of hepatosplenomegaly of this degree in a child of this age, with negative hematologic findings, is probably not significant.

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From the Department of Dermatology, Northwestern University Medical School, Herbert Rattner, M.D., Chairman.

THE JOURNAL

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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BRITISH HEALTH SERVICE

THE British national health service, having completed its third year, gives every indication of not being correctly named. It is short on health and doesn't produce much service.

After a period of time, which would seem to be adequate for a shakedown of the machinery and elimination of the bugs, there are now a half million patients on waiting lists for hospital admission. More than 10,000 of these are cases of tuberculosis in need of sanatorium care.

If the backlog of hospital patients was the result of a money-saving scheme, it might claim to be at least financially advantageous. But the service is not economical. It is frightfully expensive.

It has used up the weekly payments which are taken from pay checks, and has absorbed many millions from the general tax funds. Now it becomes necessary to charge the patients directly for half the cost of spectacles and dentures. It is anticipated that 1.3 billion dollars will be the cost for 1951.

The doctors, who are striving conscientiously to care for the sick, are greatly overworked, and at the same time are not receiving adequate remuneration. Even with its high income the health service is not able to pay its physicians a living wage. Its budget will not allow any increase in doctors' fees, and cannot provide the new hospitals which are needed desperately.

One of the largest items of expense has been the free prescription. In each of the three years there has been an average of five prescriptions dispensed for every person in the country. One reason for this is that the busy doctors, overloaded with patients with nonexistent or trivial illnesses, can devote only a few minutes to each one. The writing of a prescription becomes one graceful way of ending the interview so that the next patient may be accorded his entire three-minute consultation.

It would be interesting to know how much of this medicine is actually consumed. It is a quirk of human nature that things in which one has his own money are usually appreciated and economically used. Goods and services which are supplied free of direct cost are easily wasted.

It is difficult to understand how 50,000,000 people, who were reasonably well equipped with spectacles to start with, could possibly require 20,000,000 more pairs in three years. A good proportion of these new glasses must have been unnecessary, or have been broken or lost through carelessness.

It has been said that the British health scheme provides satisfactory medical service to everyone except those who are actually sick.

It has provided wigs, and even included spares for Sunday. It has been instrumental in admitting thousands with trivial ailments to hospitals, thus denying hospital treatment to those who need it

most. It has overloaded the doctors' offices so that symptomatic treatment is the rule of the day, and patients with significant and curable illnesses cannot be given the time for a good diagnosis.

The British health service is now faced with bankruptcy. It has cost much more than anticipated. It has not been able to provide funds for hospital construction. It cannot pay its doctors adequately. It is a good example of what happens when a government attempts to give away a vital service which, ideally, everyone should provide for himself.

INSTRUCTIONAL COURSES

THROUGHOUT this issue of THE JOURNAL you will note Instructional Course information. Preparation for this popular feature of the Annual Meeting is virtually a year-long process. In addition to detailed preparatory work by the committee throughout the year, the courses benefit from the past experience and holdover information which has been preserved from year to year by the reappointment of committeemen, and particularly the hard-working co-chairmen.

The subject matter for the courses was chosen originally from nominations by interested physicians. The same process has governed the changes in the curriculum since then. Sincere compliments to this form of postgraduate education are evidenced by the fact that such courses are being instituted by other state societies and are meeting with enthusiastic reception.

The first day of the Annual Meeting, Monday, October 29, will be Instructional Course day this year. If you have been an attendant in the past, there is no need to remind you, but if you haven't, get aboard in 1951, and have a real medical treat. The schedule and reservation blanks appear in this issue.

The faculty of the Instructional Courses for the 1951 Session of the Indiana State Medical Association is again drawn from the membership of the Indianapolis Medical Society. This unit of the state association organized the first Instructional Course for the 1943 session as a venture into a new feature of our annual sessions.

Requests for courses were studied and a curriculum of 16 classes presented. The informal discussions to groups limited to 30 "students" were enthusiastically received. Annually repeated courses have continued that response.

For the 1951 session 30 courses are to be offered on October 29. The schedule permits attendance at as many as five classes. The hours are 11:00 a.m., 1:00 p.m., 2:00 p.m., 3:00 p.m., and 4:00 p.m.

The schedule offers a selection of six classes at each hour. While there is wide variety of choice, a selection of closely related subjects can be made so as to spend the day considering circulation, pediatrics and obstetrics, mental and nervous diseases, and so forth. The faculty of the Instructional Courses has something of value to offer association members and deserves our appreciation of its willingness to put on this program.

NATIONAL FUND FOR MEDICAL EDUCATION

THE National Fund for Medical Education has made its initial distribution of grants totaling $1,132,500 to the 79 medical schools of the country. The "National Fund" was formed about two years ago by representatives of the medical profession together with those of business, industry, agriculture and labor, for the purpose of relieving the financial straits in which medical education has been placed by inflation.

Contributions from widespread sources throughout the country, together with those of the AMA's American Medical Education Foundation have produced these funds. It is expected that additional grants will be available this year.

The initial grant is small, but it is pointed out that the money is granted without strings, and may be used by each school where it is needed the most. It is given without restriction of any kind and therefore will be valuable out of proportion to its size.

The AMA is encouraging contributions from all doctors and hopes to be able to accomplish a total of one million dollars for its share in 1951. All contributions are federal income tax deductible, and may be earmarked for a particular school.

More than half of the initial grant came from the medical profession. If we continue to support this fund, we may be assured of generous help from other sources, and medical education may be freed from the threat of federal subsidy and control.

IMPROVED FEDERAL MEDICAL SERVICES

THE National Doctors Committee for Improved Federal Medical Services has been organized as an affiliate of The Citizens Committee for the Hoover Report.

It is described as a nation-wide politically nonpartisan body of medical men with the welfare of their country and their profession at heart.

Its objective is to explore the thinking of the medical profession and to bring the profession's

opinions in regard to improvements in the federal medical services to the attention of Congress.

Bills before Congress (S. 1140 and H.R. 3305 and 3688) if enacted, would create a new Department of Health, with Cabinet status, which would unify and bring under one central control the thirty-odd medical systems of the government.

The Hoover Report made many observations in regard to the uncoordinated and wasteful methods of the federal medical services. It is important that legislation designed to correct this situation be medically sound.

The national committee, under the chairmanship of Robert C. Page, M.D., is being advised by a committee of doctors representing all branches of medicine and many parts of the country. All state medical associations have been asked to assist in the formation of state committees.

SCHOOL HEALTH CONFERENCE

PLANNING for the second School Health Conference is now well along. This meeting is sponsored by the Committee on School Health and Physical Education of the Indiana State Medical Association in cooperation with the Department of Public Instruction, the Indiana State Dental Association, the School Board Men's Association, the City and County School Superintendent's Association, the Indiana State Teachers Association, and the Indiana State Board of Health.

It will be held on Wednesday, September 26, 1951, at the Claypool Hotel, Indianapolis. All physicians who are interested in school health problems are invited and urged to attend.

Registration will begin at 9:00 A.M. General meetings and group work meetings will occupy the day until 4:00 P.M.

A luncheon meeting at noon will be addressed by Governor Schricker and Dr. W. W. Bauer, director, Bureau of Health Education of the A.M.A.

The conferees will be divided into four groups for the purpose of the basic work. These groups will consider Physical Education, Emotional Health, Health Appraisal and Care and Follow Through.

Each of the groups will meet separately. A chairman, discussion leader, recorder, one to three observers and four consultants have been chosen for each work group.

The program will be closed by a discussion panel to be led by the group leaders.

Editorial Notes

The Indiana State Medical Association scholarship program for medical students has placed its first doctor in an Indiana community. Dr. Fred W. Dierdorf, who graduated in 1950 and who has recently completed an internship at Seaside Hospital in Long Beach, California, has begun practice in Winslow. Doctor Dierdorf, a native of Terre Haute, was the first doctor educated under the program and received his scholarship when he was a sophomore in Indiana University School of Medicine.

Chiropractors in the greater Louisville area are advertising that they are able to determine by examination whether a child is likely to develop infantile paralysis. They are also offering two weeks of treatment to those whom they find to be susceptible, and suggest that this much chiropractic treatment will usually prevent the disease. This is a cruel hoax, perpetrated against gullible persons and their families, by chiropractors both licensed and unlicensed. Cancer quacks usually prey on older persons who at least have the advantage of years and should know better. This chiropractor advertising is especially vicious, since it involves children.

The U. S. Army Medical Service is not only establishing a new record low in mortality figures for battle wounds in American soldiers, but is also announcing considerable success in treating wounded enemy prisoners. Approximately 37,000 prisoners have been admitted to Army hospitals in Korea. Despite their generally poor physical condition due to infectious diseases and lack of immunizations, the death rate for wounds of captured enemy personnel has been only 7 percent over a six months' period. An unusually high incidence of leprosy, smallpox, typhus, typhoid fever, tetanus and other epidemic diseases has been observed among the prisoners.

The Metropolitan Life Insurance Company has initiated a nation-wide educational program on the subject of weight control. Its slogan is "The Longer the Belt Line, the Shorter the Life Line." It is directed to and is designed to assist the estimated 25,000,000 Americans who are overweight. Movie films, pamphlets, exhibits, and materials for speeches have been prepared and are available for use by their policyholders and the general public. As all doctors know, some obese patients need all the help they can obtain in their efforts at weight reduction. Educational material of this type will be especially valuable to health agencies and other community groups.

President's Page

RAY SMITH is gone. On August fourth death came suddenly and unexpectedly to this great friend of yours and mine. For six years he served as executive secretary of our association, a position which he filled with unusual talent and devotion. He brought to this post a rare combination of abilities. Because he was so fundamentally decent and fine, he was always gracious and kindly. He represented our profession with dignity and poise. He was an able writer, a clear thinker and an ardent advocate of the highest principles of ethical conduct. Those who knew him well realize the anxiety he felt over the derelictions of a few of our members. He had a keen appreciation of the public's reaction to our profession and constantly sought to bring about better 'human relations' in our behalf. He was a tireless worker. It has been well said that although he lived but fifty-four years, he accomplished much more than many older men because of his remarkable industry and constant devotion to his obligations. The welfare of our members and of medicine was seldom away from his thoughts. To know Ray was to love and respect him. Few men lead a cleaner life. His thoughts and speech were never ordinary. Surely he is reaping the reward his life deserves. Whatever the Deity has in store for Ray would be good enough for you and me.

Alfred Edison

Ray E. Smith

"He was the soul of honor—no finer man ever lived."

THE sudden death of Ray Smith has deprived the medical profession of one of its best friends and most sincere critic. He was a man who engendered friendship and loyalty. He is mourned by a host of friends and associates with a deep sense of personal loss.

He was a tireless and efficient executive, and lived with a love for his work and devotion to duty which is seldom excelled. His passing inspired the sincere compliment of his good friend, Governor Henry Schricker—"He was the soul of honor—no finer man ever lived."



Ray had served as executive secretary of the Indiana State Medical Association, and managing editor and business manager of The Journal since May 1, 1946, when he succeeded Tom Hendricks. Prior to this he had been the first executive secretary of the Indianapolis Medical Society, and during this same period he assisted part time in the state association office.

His term as secretary was distinguished by his personal interest in many organizations devoted to public service. He represented the medical profession on a score or more of committees, and contributed his energies wholeheartedly to each of these enterprises. He was recently appointed by the Governor to the state Mental Health Council.

Ray was born in Huntington and graduated from DePauw University in 1921. He was reporter for the Franklin Evening Star, city editor of the LaPorte Argus, managing editor of the LaPorte Argus-Herald, and editor of the Michigan City Evening Dispatch.

Following this most successful career in journalism he was publicity director for the Democratic State Committee, and was made executive secretary to Governor Henry F. Schricker in 1941. At the conclusion of Mr. Schricker's first term he was a member of the State Board of Tax Commissioners under Governor Ralph Gates.

Ray passed away suddenly on August 4 at the height of a busy career. The Indianapolis Star, in an editorial tribute entitled "A Wise and Faithful Citizen," said: "Not how long it is, but how good it is—that is the test of life, according to a reliable old philosopher. By that measure the life of Ray E. Smith, executive secretary of the Indiana State Medical Society, who died Saturday at the age of 54, was ripe in achievement and rich in friendship."

Medical Panorama by the Associate Editor

What Leads To "Grievances"?

Grievance committees are comparatively new in American medicine, and the report of one from the Iowa State Medical Society published in its *Journal* for July, 1951, is interesting for several reasons. For one thing, it shows that such a committee is useful. Furthermore, cooperation was "excellent," on both sides—lay and professional. Finally, a list is given of the occurrences most often found to be the basis or inception of a grievance. These points are shown in the following extracts from the report:

At the first meetings, the cases were those which had accumulated prior to the inception of the committee. A few were received during the summer, but after the Press-Radio Conference in September, many more came in. We still continue to receive cases.

* * * *

Cooperation from the profession has been excellent with one exception. The doctors have complimented the committee in several cases for the manner in which the cases were handled. The same is true of the lay persons submitting the grievances.

The following points are those mostly responsible for the filing of grievances with the committee:

1. Remarks to a patient regarding other doctor's treatment or charges;
2. Discussion between doctors within ear shot of patients regarding prognosis, severity of case, finances, and general reputation;
3. Lack of diplomacy and tact in refusing to accept a case, refusing to make a call, telephone conversations, refusing to make emergencies ok for a prescription, and discussing fees, especially before treatment;
4. Misunderstanding by patients;
5. Misquoting doctors by patients;
6. Patients who expect to receive a favorable result or cure or else they do not expect to pay their obligation;
7. Doctors who guarantee good results or a cure;
8. Lack of the knowledge of the fee schedule on the part of patients;
9. Exorbitant fees, (surprisingly few);
10. Poor results from surgery or traumatic cases;
11. Careless remarks of interns or students;
12. Negligence, actual or assumed.

Evidently, a slip of the tongue is a commoner cause of trouble than a slip of the scalpel. Both are to be avoided.

Useful But Dangerous

Under the title "Dicumarol Can Be Dangerous," an editorial in *The Journal of the Iowa State Medical Society* goes into the matter too thoroughly for us to reprint the entire article, but these excerpts are of especial interest:

In a series of over 900 cases at Massachusetts General Hospital in which dicumarol was used prophylactically, there were no fatal pulmonary emboli, but there were two deaths from hemorrhage. In a comparable series of cases in which dicumarol was not used prophylactically there was no fatal pulmonary embolism.

The statistics available on pulmonary emboli were compiled before it became common practice to encourage early ambulation, early movement in bed, proper bed posture and better postoperative care, with respect to fluids, electrolyte and nitrogen balance. Evans and Boller, after a study of their series of 45,000 surgical cases at the Lahey Clinic, concluded that there was a one-third reduction in postoperative thromboembolic complications on this regimen.

It also appears that the problem is not as simple as doing daily prothrombin times, because other factors have been reported. In addition, our present tests leave much to be desired:

A review of the literature reveals that the majority of the fatalities are caused by gross over-dosage. In addition, poor results have occurred because of the lack of uniformity in prothrombin determinations. There is a burning need for a more standardized laboratory test that is simpler and more accurate. It is difficult to obtain a safe prothrombin level; moreover, a low prothrombin level does not necessarily prevent thrombus formation.

* * * *

Failure to recognize the limitations of tests for prothrombin time may obstruct effective therapy. Under the false impression that the patient is being protected from the thromboembolic complications by the use of dicumarol, one may withhold venous ligation until it is too late.

In the meantime, clinical judgment will continue to be the best guide to treatment.

St. Luke, 2:7—A Modern Version

Chickens come home to roost, they say,—even when everything is "planned," as witness the following, clipped from the May, 1951 *Connecticut State Medical Journal:*

BRITAIN'S BABIES TO BE BORN AT HOME

On March 2 London physicians, according to a Reuter dispatch, recommended that the government close all hospitals to all maternity cases except those in which complications are expected. This follows the shortage of beds in hospitals all of which are now owned and operated by the government. People are dying in their homes because of inability to secure hospital admission. Since the beginning of the operation of National Health Service the hospitals have become filled with the chronically ill. No one wants to turn them out into the street, hence beds for emergency illness are at a premium.

Instead of three out of every four London babies being born in hospitals as is now the case, the physicians

believe a larger number could just as well be born at home.

Britain's hospitals have about half a million beds but at least one-tenth of these are empty because the government does not hire sufficient nurses to care for the beds if occupied.

It seems that while "muddling through" our British brethren have been bemuddled, beaddled, befuddled and bumfoozled,—with apologies to good Dr. Rabelais. Would someone care to page Oscar Ewing?

PAUL ENTREATS PAUL

A commentator, Paul Harvey, stepped into the fight against socialization of medicine (and other things) not long ago, and prompted an article in the *Rocky Mountain Medical Journal* entitled "Dr. Hawley: Come Back to the Fold!" We pass on to you bits of the article and quite a little quote from Harvey:

The big point of Paul Harvey's broadcast, as far as doctors are concerned, was his shot at Dr. Paul Hawley. He said, "I sure hated to see Paul Hawley throw in the towel the other day when he said 'compulsory health insurance is inevitable.' "

* * * *

Let us quote a few of Mr. Harvey's paragraphs:

"Understand, I don't believe in continuing a fruitless, vain battle for a lost cause. But out in the good green grass roots of America there are a lot of folks who don't say much, but they'll fight in your army if you'll lead them. Dr. Hawley, would you say to one of your patients: 'Your disease has always been fatal, so I'm not going to bother to doctor you any longer?' Of course you wouldn't. You'd live up to your Hippocratic oath until that person had been dead for an hour. And maybe you'd keep trying after that. You've said you're opposed to mercy killing, because while there's life there's hope. All right! Then don't kill off good medicine in this country and all other freedoms that are allied with it, just because the opposition has some crack salesmen in the field.

"Do you realize, Dr. Hawley, that they're frauds? They're trying to peddle this super stateism as something new. When, actually, free competitive American capitalism is the only new experiment in government in the history of mankind. We often liken the Roman Empire to our own . . . because the Romans did enjoy a dignity and standard of living most nearly approaching, comparatively speaking, our own. What happened? The empire degenerated morally, socially, and economically. Immorality reached its height with the crucifixion of Christ. Then the empire started down. But . . . then what?

"About 290 years after Christ, a Roman Emperor named Diocletian took over. And he really grabbed the bull by the horns. He took over in a period of turmoil and severe depression. You think the New Deal is new? The first thing Diocletian did was to close the banks and call in the gold and start a broad program of reform. He reduced the power of the Senate, and organized and delegated that power to little government bureaus. He raised the taxes. And put millions on the public payroll. But when this failed to do the job, the country was still in a mess. He asked more personal powers for himself. For a brief while they were standby powers. Then he used them, all at once. He froze wages, he froze prices, he froze jobs and he stopped profits. He dictated to the farmer what he should plant and when and how much he should sell it for. And he rationed food.

"No . . . that super-state approach where the government runs the affairs of the individual is *not* new. Whether it's called Communism, or Feudalism, or Socialism, it's not new.

"But let's finish with this Emperor who reigned in the year 300. What happened? The labor market closed down. Incentive was gone. Farm life became dependent on bureaucratic red tape and exorbitant taxes cost the farmer his land. He kept for himself only enough to grow turnips for his family and lost the rest to the state. Insufficient food and industry caused cities to decline. Life became stagnated. And the Roman Empire passed into what history has recorded as the Dark Ages, lasting a thousand years.

"Dr. Hawley, do you know in spite of this that the Socialists in our midst are still calling what they're peddling 'progressive'?

"No, what we need is not a better product, but a more determined bunch of salesmen. And they're so few. I sure hate to lose you."

Thank you, Mr. Harvey! We always want General Hawley on our side and we don't want to see him lose his fight or to make public speeches while he is embittered. He is one of our biggest men. We are proud of his record as a Major General in the Army, later as Chief Medical Director of the Veteran's Administration, and now as Director of the American College of Surgeons. He is a fine physician from a family of doctors. He is a distinguished executive and a powerful public speaker. We are confident that he will continue to fight on our side and that he will not let us down any more than our profession will let down the people of America!

Here's hoping!

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

MEDICAL PROGRAM

Although diehard doctrinaires of the Left may continue their campaign for compulsory health insurance, there is ample evidence to support the conclusion of Dr. Elmer L. Henderson, president of the American Medical Association, that the "threat of socialized medicine is now dispelled, at least temporarily."

That is due to a combination of factors—the urgency of the mobilization program, the effectiveness of the doctors in presenting their case, the common sense of the American people and the object lesson of the British experiment with socialized medicine. There can be little doubt that the American people have turned thumbs down on this visionary extension of socialized regimentation into their private lives.

Dr. Henderson is realistic, however, in recognizing that some elements of the national health problem remain unsolved and in calling on his fellow physicians to take the same constructive leadership in meeting them that they have exercised in protecting their profession and the welfare of the American people.

The 15-point program Dr. Henderson has advanced to promote the national health and to foster and maintain high standards of medical care is evidence that the profession is prepared to accept and meet its responsibilities to the American people. But that has been long apparent to anyone who based his conclusions on personal observation of the activities and sacrifices of American physicians, rather than on juggled statistics, biased complaints, prejudice and the theories of the dreamers. —*Indianapolis News.*

COUNTRY DOCTORS HAVE IT BETTER

Not the least of the satisfactions that compensate the physician who chooses to practice in a small city or town is a higher average income than his colleague in a large metropolitan center earns, according to cold figures compiled by the United States Department of Commerce. He not only has a larger dollar income, but his real income advantage is even greater, in view of the well known fact that living is more expensive in thickly congested urban areas. This inducement, plus the opportunity to be of service where they are most needed, should go far toward correcting the apparent shortage of doctors in rural communities.

The income survey, in which 55,000 physicians assisted, offers economic proof that a nation-wide shortage of physicians does not exist, as proponents of socialized medicine like to argue. Physicians' incomes have risen percentagewise in almost exact proportion to the average income of the American people, which suggests that supply and demand are rather nicely balanced. On the other hand, the income differential within the profession itself suggests there actually is an over-supply of physicians in the big cities. The significance of this fact will not escape the young medical graduate looking for a place to hang out his shingle. —*Indianapolis Star.*

The Instructional Courses of the 1951 Session will present discussion of "Treatment of Anemias and Allied Conditions," "Newer Managements of the Stomach and Bowel," "Diagnosis and Treatment of Respiratory Diseases," and "The Backache Problem."

CESAREAN SECTION RATES IN INDIANA

ROBERT E. JEWETT, M.D.*

INDIANAPOLIS

THE factual data are presented by the Committee on Maternal and Child Health of the Indiana State Medical Association.[1] This has been compiled for the medical profession and medical staffs of the hospitals in Indiana, and it is a continuing study, a sequel to a previous report covering the broad field of "Maternal, Newborn and Premature Infant Care, and Cesarean Sections in Indiana Hospitals."[2]

There is an obvious variation in Cesarean section rates which should be of interest to hospital medical staffs. The hospitals presenting no Cesarean sections in the tables are those in which no major surgery is performed.

* Director of Division of Maternal and Child Health, Indiana State Board of Health.

[1] Committee on Maternal and Child Health: Neal E. Baxter, Bloomington, Chairman; E. R. Carlo, Ft. Wayne; Robert E. Jewett, Indianapolis; G. W. Gustafson, Indianapolis; Rex W. Dixon, Anderson; C. O. McCormick, Sr., Indianapolis; H. W. Eggers, Hammond; Carl P. Huber, Indianapolis; Lyman T. Meiks, Indianapolis.

[2] Journal of the Indiana State Medical Association, November, 1947.

LIVE BIRTHS AND CESAREAN SECTIONS

Number and Percentages by Hospitals, Indiana, 1949 and 1950

Hospital	City	Live Births		Number Cesarean		Percent Cesarean	
		1949	1950	1949	1950	1949	1950
TOTALS (State of Indiana) All Hospitals		84,426	86,038	3,488	3,599	4.13	4.18
Adams County Memorial	Decatur	643	560	38	39	5.91	6.96
Methodist	Ft. Wayne	1,183	982	26	22	2.20	2.24
Lutheran	Ft. Wayne	2,034	2,038	64	72	3.15	3.53
St. Joseph	Ft. Wayne	1,867	1,871	37	38	1.98	2.03
Bartholomew County	Columbus	903	970	25	24	2.77	2.47
Blackford County	Hartford City	327	318	7	14	2.14	4.40
Witham Memorial	Lebanon	670	719	20	22	2.99	3.06
Memorial	Logansport	531	485	37	38	6.97	7.84
St. Joseph	Logansport	517	582	16	21	3.09*	3.61
Clark County Memorial	Jeffersonville	758	806	39	29	5.15*	3.60
Clay County	Brazil	482	423	32	22	6.64	5.20
Clinton County	Frankfort	611	579	19	16	3.11	2.76
Daviess County	Washington	898	827	84	87	9.35	10.52
Decatur County	Greensburg	411	390	52	50	12.65	12.82
Dr. Bonnell M. Souder	Auburn	202	188	4	6	1.98	3.19
Sacred Heart	Garrett	376	315	11	10	2.93	3.17
Sanders General	Auburn	131	159	4	4	3.05	2.52
Ball Memorial	Muncie	2,265	2,184	72	95	3.18	4.35
Stork	Huntingburg	588	596	40	32	6.80	5.37
Elkhart General	Elkhart	1,299	1,392	53	43	4.08	3.09
Goshen	Goshen	941	796	49	56	5.21	7.04
Fayette Memorial	Connersville	629	626	19	26	3.02	4.15
St. Edwards	New Albany	1,346	1,316	63	59	4.68	4.48
Woodlawn	Rochester	373	418	47	51	12.60	12.20
Gibson General	Princeton	592	647	11	9	1.86	1.39
Wood Hospital & Clinic	Oakland City	174	90	1	2	0.57	2.22*
Marion General	Marion	1,405	1,256	44	51	3.13	4.06
Freeman Greene County	Linton	490	516	95	93	19.39	18.02
Hamilton County	Noblesville	403	428	28	39	6.95*	9.11
Harrison County	Corydon		134		5		3.73*
Henry County	New Castle	1,309	1,255	53	56	4.05	4.46
St. Joseph Memorial	Kokomo	1,456	1,401	54	52	3.71	3.71
Huntington County	Huntington	625	680	9	9	1.44*	1.32
Jackson Co. Schneck Mem.	Seymour	727	773	36	36	4.95	4.66
Jasper County	Rensselaer	469	516	32	31	6.82	6.01
Jay County	Portland	419	443	77	74	18.38	16.70
King's Daughters'	Madison	519	556	24	34	4.62	6.12
Johnson County	Franklin	514	573	13	7	2.53	1.22

* Estimated from Incomplete Reports

Hospital	City	Live Births		Number Cesarean		Percent Cesarean	
		1949	1950	1949	1950	1949	1950
Good Samaritan	Vincennes	1,149	1,043	44	39	3.83	3.74
McDonald	Warsaw	437	418	9	6	2.06	1.44
Murphy Medical Center	Warsaw	179	200	11	14	6.15	7.00
LaGrange County	LaGrange		84		7		8.33*
Methodist of Gary, Inc.	Gary	2,777	2,984	72	88	2.59	2.95
St. Catherine	East Chicago	2,164	2,086	69	69	3.19	3.31
St. Margaret	Hammond	2,862	2,735	78	93	2.73	3.40
St. Mary Mercy	Gary	2,107	2,020	54	46	2.56	2.28
Fairview	LaPorte	653	692	57	57	8.73	8.24
Clinic	Michigan City	171	166	20	23	11.70	13.86*
Holy Family	LaPorte	592	472	19	27	3.21	5.72
St. Anthony	Michigan City	714	772	29	27	4.06	3.50
Dunn Memorial	Bedford	848	830	49	45	5.78	5.42
Mercy	Elwood	681	774	12	15	1.76	1.94
St. John's Hickey Mem.	Anderson	1,919	1,729	175	167	9.12	9.66*
Indianapolis General	Indianapolis	1,463	1,518	46	47	3.14	3.10
I.U. Med. Center (Coleman)	Indianapolis	1,833	2,147	104	136	5.67	6.33
Methodist	Indianapolis	5,054	5,032	253	199	5.01	3.95
St. Elizabeth Maternity	Indianapolis	27	30	0	0	0	0
St. Francis	Beech Grove	1,973	1,917	25	16	1.27	0.83
St. Vincent's	Indianapolis	267	2,037	9	65	3.37*	3.19*
Kelly	Argos	56		0		0*	
Community	Bremen	162	123	0	0	0*	0*
Parkview	Plymouth	444	343	8	8	1.80	2.33*
Dukes-Miami County	Peru	572	619	20	39	3.50*	6.30
Bloomington	Bloomington	1,023	1,054	57	63	5.57	5.98
Montgomery Co. Culver Union	Crawfordsville	830	858	31	31	3.73	3.69
Morgan Co. Memorial	Martinsville	299	365	1	3	0.33*	0.82
Luckey	Wolflake	276	252	5	7	1.81	2.78
McCray Memorial	Kendallville	438	462	38	36	8.68	7.79
Clark	Paoli	40		0		0*	
Parkview	Tell City	195	152	1	0	0.51	0*
Perry County	Tell City		73		0		0*
Porter Memorial	Valparaiso	783	743	27	22	3.45	2.96
Carneal's Private	Winamac	116	127	0	2	0	1.57*
Putnam County	Greencastle	443	441	16	13	3.61	2.95
Randolph County	Winchester	455	347	39	43	8.57	12.39*
Union City Memorial	Union City	167	102	19	11	11.38*	10.78*
Margaret Mary	Batesville	727	726	13	11	1.79	1.51
Whitlatch Clinic	Milan	392	345	11	8	2.81	2.32
Rushville City	Rushville	362		10		2.76*	
Rush Memorial	Rushville		378		12		3.17
Napper	Scottsburg	354	289	0	0	0	0*
William S. Major	Shelbyville	681	691	22	23	3.23	3.33
Memorial	South Bend	1,700	2,245	125	131	7.35*	5.84
St. Joseph	Mishawaka	1,091	1,069	25	20	2.29	1.87
St. Joseph	South Bend	1,900	1,865	56	69	2.95	3.70
South Bend Osteopathic	South Bend	277	423	10	14	3.61*	3.31
Cameron	Angola	187	164	7	8	3.74	4.88
Elmhurst	Angola	185	159	1	4	0.54	2.52
Mary Sherman	Sullivan	456	455	7	9	1.54	1.98
Burkhardt Emergency	Tipton	67		0		0	
Lafayette Home	Lafayette	1,047	1,053	45	48	4.30	4.56
St. Elizabeth	Lafayette	1,678	1,532	53	41	3.16	2.68
Tipton Co. Memorial	Tipton		30		0		0*
Protestant Deaconess	Evansville	2,316	2,364	55	72	2.37*	3.05*
St. Mary's	Evansville	1,133	1,147	33	26	2.91	2.27
Welborn Mem. Baptist	Evansville	697	838	50	40	7.17	4.77
Vermillion County	Clinton	468	461	32	20	6.84	4.34
Florence Crittendon Home	Terre Haute	42		0		0*	
Hoover Sanatorium	Terre Haute	61	12	2	0	3.28*	0*
St. Anthony	Terre Haute	1,386	1,267	28	26	2.02	2.05
Union	Terre Haute	1,088	1,115	38	69	3.49	6.19
Wabash County	Wabash	573	552	36	45	6.28	8.15
Community	Williamsport	167	123	0	0	0	0*
Washington County	Salem		42		3		7.14*
Reid Memorial	Richmond	1,671	1,656	81	49	4.85	2.96
Clinic	Bluffton	148	142	4	1	2.70	0.70*
Wells County	Bluffton	316	340	12	12	3.80	3.53

* Estimated from Incomplete Reports

1949—There are 11 hospitals with Cesarean Section percents over 8.00.

1950—There are 13 hospitals with Cesarean Section percents over 8.00.

SUMMARY OF THE WORK OF THE DISABILITY INSURANCE COMMITTEE

THE Special Committee on Disability Insurance appointed by the president, upon the authorization of the Council, made a serious effort to find some basis upon which there could be a list of definite recommendations regarding the contents of a disability insurance policy. They requested insurance companies to send in samples of their policies for the committee to study and they informed insurance companies of the work the committee was trying to do. A substantial number of insurance companies responded. The committee thereby acquired a large number of sample policies, of which it made what might be called a differential study. The members of the committee also had conferences with a substantial number of representatives of insurance companies.

As the work of the committee progressed, it became more and more apparent that what each insurance company was seeking to do was to find the ideal policy that would satisfy the largest number of physicians who might desire disability insurance. This ideal policy, of course, would have to be satisfactory as to premium as well as to coverage in order to be marketable. Then, further, it would have to satisfy the fundamental requirement of financial soundness. If the policy coverage was not supported by the premium, of course, the policy would be discontinued by the company. If the premium was not satisfactory to the physician the policy could not be sold or would be discontinued by the physician. The difficulty of knowing exactly how much could be put into the coverage in relation to the amount that would be required for a premium presented the hardest kind of actuarial questions.

So far as the committee was concerned it was not satisfied itself that it could find the ideal policy which it could recommend to all physicians. One company would emphasize a particular risk against which it insured; another company, a different risk; and a third company, a third risk. The rates charged varied also in relation to the risks covered. Then there was a variation in the risks and the rates based upon the stringency or liberality of underwriting regulations, that is, of the rules which determined whether one could get insurance at all or not, and, if he could, whether he would be rated up on the premium to be paid.

The committee made interim reports to the Council as its work progressed and attempted to arrive at a set of specifications for a policy which could be sent to all insurance companies with a statement that if they would write a policy containing those specifications the policy would be approved as one to be recommended to the physicians of the state. But in view of the conflicting arguments regarding the different types of policies and the different problems to be met in order to produce one policy that would satisfy the actual needs of physicians in the multitude of different situations they occupy, it became more and more apparent that that task could not be completed with any assurance that the results would be satisfactory. At least the evidence began to accumulate that the medical association would be engulfed in a turbulent sea of controversy among insurance companies if it insisted on carrying out the plan that seemed so attractive in the beginning.

Finally, after several conferences with the Executive Committee and the Council, this special committee, with the approval of the Council and the Executive Committee, has decided not to make any report that would include definite specifications for policies. This committee is convinced that the best it can do at this time is to urge upon every physician the importance of studying the disability insurance policy which anyone may offer to sell him, from the viewpoint of his own particular situation, and to do this with the assurance that there are so many different policies written by so many dependable companies that if one policy does not meet what he believes to be his own needs, he has a fair chance of getting such a policy from some other company.

It is hoped that the medical profession will understand the difficulty which confronted this committee and realize that the Committee was always conscious of the importance of preserving the highest quality of public relations between the medical profession and the entire insurance industry. The committee does not regard the time which it spent on this problem as entirely fruitless. It believes that this work was necessary and served a good purpose even though it results in nothing more than the discovery of the tremendous difficulty in the problem assigned to it, and the conclusion that this is a problem in that class in which a large burden of the responsibility for a proper solution must be left to those who are professionals in that field.

We believe it is wise for physicians to become acquainted with dependable, well-trained insurance men, established in their own communities, who rely for their future on the confidence they create not only in the manner in which they obtain insurance business but in their integrity in handling the claims that arise out of it.

M. B. Catlett, M.D., *Chairman*

ORDER YOUR TICKETS FOR THE 1951 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1951 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at Murat Temple, Indianapolis, is now complete. All classes are on Monday, October 29, 1951.

(Attendance at these classes by members of the Indiana Academy of General Practice will be accepted as postgraduate training credit by that organization.)

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is $1.00 per class with a maximum charge of $3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now! Classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE

Hr.	Room A	Room B	Room C	Room D	Room E	Room F
11 to 12	Bedside and Office Diagnosis of Cardiac and Vascular Problems Course 1	The Psychological Management of Patients Course 2	Pediatric Problems Course 3	The Newer Drugs Course 4	The Diagnosis and Treatment of Common Skin Diseases Course 5	Corns, Bunions, and Painful Feet Course 6
	NOON RECESS					
1 to 2	The Newer Management of Coronary Disease, Rheumatic Fever, and Congestive Failure Course 7	The Demonstration of A Neurological Examination Course 8	Infant Feeding Problems Course 9	ACTH and Cortisone Course 10	Office Diagnosis and Treatment of Common Genitourinary Conditions Course 11	Minor Home, Farm and Factory Emergencies Course 12
2 to 3	Salt Metabolism in Heart Failure and Hypertension Course 13	The Headache Problem Course 14	Impotence and Infertility Course 15	The Management of Diabetes Mellitus Course 16	Diagnosis and Treatment of Respiratory Diseases Course 17	Management of the Elderly Course 18
3 to 4	The Demonstration of A Physical Examination Course 19	How to Improve Your Own Public Relations Course 20	Obstetrical Emergencies Course 21	Bedside and Office Diagnosis of Cardiac and Vascular Diseases Course 22	The Management of Anorectal Conditions Course 23	Management of The Menopause Syndrome Course 24
4 to 5	The Treatment of Anemias and Allied Conditions Course 25	Management of the Neurotic Course 26	The Diagnosis and Treatment of Common Skin Diseases Course 27	Newer Managements of The Stomach and Bowel Course 28	Diagnosis and Management of Common Gynecological Problems Course 29	The Backache Problem Course 30

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APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for $1.00; $2.00; $3.00. Please reserve tickets for the following Instructional Courses:

	11:00 A.M.	1:00 P.M.	2:00 P.M.	3:00 P.M.	4:00 P.M.
First choice.....	No.:	No.:	No.:	No.:	No.:
Second choice.....	No.:	No.:	No.:	No.:	No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, October 29, 1951.

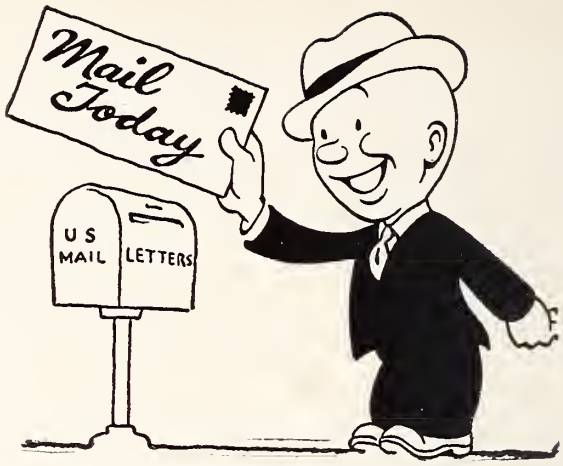
Signed: .....M.D.

Address: .....

Time to Make Hotel Reservation

Going to attend the annual session of the Indiana State Medical Association in Indianapolis on Monday, Tuesday and Wednesday, October 29, 30 and 31, 1951?

It's time to make your hotel reservation.



Hotels	Rates (Start) Single	Double
Antlers, 750 N. Meridian	$4.25	$6.25
Barnes, 233 McCrea Place	$2.50	$3.50
Barton, 505 N. Delaware	$2.75	$4.00
Claypool, 14 N. Illinois	$4.60	$6.30
Harrison, 51 N. Capitol	$3.75	$5.75
Jones, 248 S. Illinois	$2.50	$4.50
Lincoln, 117 W. Washington	$4.00	$6.25
Linden, 311 N. Illinois	$2.00	$3.50
Marott, 2625 N. Meridian	$6.00	$8.00
New English, 6 W. Michigan	$2.00	$3.00
Pennsylvania, 947 N. Penn	$3.50	$5.00
Severin, 201 S. Illinois	$4.50	$6.50
Sheffield, 958 N. Pennsylvania	$3.50	$6.00
Spink Arms, 410 N. Meridian	$3.50	$6.00
Warren, 123 S. Illinois	$4.00	$6.00
Washington, 34 E. Washington	$3.50	$5.00

TIME OF EVENTS

MONDAY, OCTOBER 29

Instructional Courses, Stag Party, Golf, Trapshoot, Party for Women.

TUESDAY, OCTOBER 30

Scientific Program, entertainment at night for doctors and wives, Murat Theater.

WEDNESDAY, OCTOBER 31

Scientific Program, reception for Fifty Year Club, annual dinner and dance.

FORM FOR MAKING HOTEL RESERVATION

(Clip out this form, fill it out, and mail to hotel of your choice)

You are requested to reserve the following accommodations during the annual meeting of the Indiana State Medical Association, October 29, 30 and 31, 1951, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price.....

☐ Twin Bed Room with bath ☐ Suite

Arrival date .....A. M. .....P. M.

Departure date .....A. M. .....P. M.

Name .....

Address .....

.....

.....

News Notes

NOTICE FOR TRAPSHOOTERS

The annual trapshoot will be held Monday, October 29, 1951, at the Indiana Gun Club, near Indianapolis. Every physician wishing to participate in this event is asked to notify the Committee on Trapshoot. Dr. Louis T. Need, 1927 S. Meridian Street, Indianapolis 25, is chairman.

DINNER FOR WOMEN PHYSICIANS

The annual dinner for women physicians during the state meeting will be at 6:00 p.m., on Monday, October 29. The place will be announced later.

SYMPOSIUM ON CHEMISTRY OF ACTH

Armour and Company will sponsor an international symposium on the chemistry of ACTH to be held on September 18 at the Palmer House, Chicago. American and foreign chemists and clinicians will participate. Visitors from abroad will come from England and Sweden.

OPERATING ROOM TECHNIQUE INSTITUTE

Under the sponsorship of Indiana University Medical Center a 5-day Institute on Operating Room Technique wil be conducted by Dr. Carl Walter of Harvard University at the Indiana State Board of Health Building in Indianapolis, September 10 to 15. This course is of special interest to operating room nurses and sterile supply supervisors. Tuition is $35.00.

Application and information concerning hotel reservations, meals, etc. may be obtained by writing to Esther Pittman, Indiana University Medical Center, Indianapolis. Applications may also be obtained from Dr. Carl Walter, Peter Bent Brigham Hospital, Boston, Mass. Only a limited number of persons can be accommodated.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION CONVENTION

The sixteenth annual convention of the National Gastroenterological Association will be held at the Drake Hotel, in Chicago, on September 17, 18 and 19. Immediately following the convention, on September 20, 21 and 22, the association is conducting a course in Postgraduate Gastroenterology. For complete information address the secretary, at 1819 Broadway, New York 23.

Effective August 10, the office of the **American Board of Obstetrics and Gynecology** is located at 2105 Adelbert Road, Cleveland 6. Dr. Robert L. Faulkner is the secretary.

INTERNATIONAL COLLEGE OF SURGEONS ASSEMBLY

The sixteenth annual assembly of the United States and Canadian chapters of the International College of Surgeons will be held at the Palmer House in Chicago, on September 10, 11, 12 and 13.

Four Indiana physicians are on the program. Dr. Willis D. Gatch, of Indianapolis, will present a paper on "The Causes of Death from Bowel Obstruction, with Deductions on Treatment." Dr. Thomas B. Noble, Jr., of Indianapolis, is one of the discussants on a panel on "Acute Intestinal Obstruction." Dr. George J. Garceau, of Indianapolis, will be one of the discussants of a paper presented by Dr. Henry W. Meyerding, of Rochester, Minnesota, on "Some Recent Advances in Surgery of the Bones and Joints." Dr. W. Burleigh Matthew, of Indianapolis, will present a paper on "Occupational Injuries of the Eye and Their Treatment."

For a copy of the final program, write the secretary, 1516 Lake Shore Drive, Chicago, Illinois.

WELLS COUNTY CLINICAL CONFERENCE

The fifth annual Fall Clinical Conference, given by the Wells County Medical Society, will be held on October 10, at the Parlor City Country Club, at Bluffton. Speakers include Dr. A. C. Ivy, of Chicago, Dr. Carl O. Rice, of Minneapolis, Dr. Stanley Gibson, of Chicago, Dr. F. J. Hodges, of Ann Arbor, Dr. Elmer R. Maurer, of Cincinnati, and Dr. George Bond, of Indianapolis. All physicians are invited to attend.

FISKE FUND PRIZE DISSERTATION

The Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce the following subject for the prize dissertation of 1951:

"The Present Status of Adreno-Cortical Hormone Therapy—Its Uses and Limitations."

For the best dissertation a prize of $200 is offered. Dissertations must be submitted by December 2, 1951, with a motto thereon, and with it a sealed envelope bearing the same motto inscribed on the outside, with the name and address of the author within. The successful author will also agree to read his paper before the Rhode Island Medical Society at its Annual Meeting in May, 1952. Copy must be typewritten, double spaced and should not exceed 10,000 words. For further information write the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

AMBULATORY FRACTURE ASSOCIATON MEETING

The twelfth annual meeting of the Ambulatory Fracture Association will be held at the Arrowhead Springs Hotel in San Bernardino, California, October 8 to 11. Scientific papers will be confined to the various treatments of fractures and their complications. The registration fee is $15.00, and the meeting is open to nonmembers of the association. For further information, address the association at Bloomington, Illinois.

DOCTOR HUSSEY NEW GP ASSOCIATE EDITOR

Dr. Hugh H. Hussey, Associate Professor of Medicine at Georgetown University, Washington, D. C., has been appointed associate editor of *GP*, published by the American Academy of General Practice, according to an announcement by Mac F. Cahal, managing publisher, in the August issue of that journal. The announcement pointed out that the rapid growth of the publication during the past year and one-half has thrown a steadily increasing burden on the medical editor, Dr. Walter C. Alvarez.

INDIANA AT WAR: CIVILIAN DIRECTORY

Many of our members will be personally interested in the appearance of a new book, *Indiana at War: Civilian Directory*, which has just been published by the Indiana War History Commission. If you served on a selective service board, or in a civilian defense council or with a Procurement and Assignment Committee or in any other civilian agency in Indiana which helped the war effort along during the Second World War, your name probably appears in this book. It lists more than 30,000 Hoosiers who engaged in these activities and describes what they did. Never before has the contribution of the civilian to the winning of a great war received such thorough and accurate attention.

The role played by the Indiana State Medical Association and Indiana physicians in World War II is adequately treated in this book. Four pages are devoted exclusively to the Association itself, 49 more to examining physicians appointed by Selective Service, and five pages to the Procurement and Assignment Service for Physicians headed by Dr. Charles R. Bird. Brief histories of wartime achievements are followed by a roster of the state officers and of the principal wartime committees. Other sections of the book deal with the medical schools, Red Cross, Emergency Medical Services, public health agencies, and other organizations in which physicians took a prominent part.

Copies of this book may be ordered from the Indiana University Press at Bloomington for $12.50, which represents a fraction of the cost of producing the book.

ANNUAL CONVENTION OF MILITARY SURGEONS

The 58th Annual Convention of the Association of Military Surgeons of the United States will be held at the Palmer House in Chicago, October 8 to 10. Members of allied medical services such as nursing, dentistry, veterinary medicine, women's medical speciality corps, and medical service corps, as well as physicians, will participate in the sessions. Advances in military medicine since World War II, and current problems arising out of the critical world situation and the Korean conflict, will be discussed.

BLUE SHIELD COVERAGE FOR STEELWORKERS

The following statement has been released by the United States Steel Company and the United Steelworkers of America:

An agreement has been concluded between the United States Steel Company and the United Steelworkers of America (C.I.O.), providing for additional insurance benefits within the framework of the present insurance and pension agreement. This is made possible at this time as a result of the operating experience under the present insurance plan.

Commencing August 1, 1951, Blue Shield surgical benefits for both employees and dependents were added to the present life, accident and sickness insurance for employees and hospitalization benefits for employees and dependents. The surgical benefits will be provided without change in employee and employer contributions, unless a point is reached where current contributions will not support the cost of the expanded benefits.

ATLANTA COMMUNICABLE DISEASE CENTER DIAGNOSTIC SERVICE DISCONTINUED

Word has been received by Dr. L. E. Burney, State Health Commissioner, that the Communicable Disease Center in Atlanta will not receive specimens for laboratory examination after August 1, 1951 from any source except State Laboratories. After that date, therefore, such specimens as heretofore might have been sent to Atlanta from private laboratories or physicians should be sent to the Indiana State Board of Health. When received there the examination will be made if the laboratory is equipped to make it. This arrangement should serve to expedite reporting in most instances as a review of the examinations made at the C.D.C. during the past two years indicates that most of them were the kind routinely made in the State Laboratory. In those instances where the examination requested is not one that can be performed in the State Laboratory, the specimen will be forwarded to the C.D.C. where the test will be made.

The Woman's Auxiliary to the Indiana State Medical Association has planned a dinner and entertainment at the Indianapolis Athletic Club, at 6:30 p.m. on Monday, October 29.

On Tuesday, October 30, there will be a board meeting at the Indianapolis Athletic Club, at 10:00 a.m., and at 12:30 a luncheon and bridge, also at the Indianapolis Athletic Club.

At 2:00 p.m. on Wednesday, October 31, there will be a fashion show and tea in Block's Auditorium.

Dr. Dan Urschel, of Mentone, was recently elected a senior member of the American Federation for Clinical Research. This was based on his clinical research in brucellosis and diseases of the heart.

Dr. Cecil R. Burket is now associated in practice with **Dr. Otis R. Bowen** at Bremen. A native of Osceola, Doctor Burket spent his internship in Memorial Hospital in South Bend, following graduation from Indiana University School of Medicine.

Announcement has been made of the association of **Dr. C. Ray Bjorklund** with **Dr. L. E. Dupes** in the practice of medicine and surgery at Hobart.

Dr. Emil H. Bergendahl is now associated in the practice of ophthalmology with **Dr. Carleton Keck** at the Duemling Clinic in Fort Wayne. A native of Manhasset, New York, and a graduate of the University of Minnesota, Doctor Bergendahl recently completed postgraduate work at Research and Education Hospital of the University of Illinois, and at Illinois Eye and Ear Infirmary.

Announcement has been made of the association of **Dr. Joseph McKinley** with **Dr. F. S. Crockett** in the practice of urology in new offices, at 312 Lafayette Life Building, Lafayette.

Dr. Frederick W. Bigler has opened an office in Goshen for the practice of medicine. He is a 1950 graduate of Indiana University School of Medicine, and interned at Indianapolis General Hospital. He is a veteran of World War II.

Dr. Donald P. Bixler has moved to Anderson from Louisville, Kentucky, where he will practice ophthalmology. He is a graduate of Indiana University School of Medicine.

Dr. Clyde G. Culbertson, of Indianapolis, has just returned from the British Isles, where he was a speaker at the meeting of the International Congress of Clinical Pathology.

An office for general practice has been opened at 6002 Windsor Drive, in Indianapolis, by **Dr. George T. Tindall, Jr.**, a 1950 graduate of Indiana University School of Medicine. He has just completed his internship at Indianapolis General Hospital.

Upon completion of postgraduate work in diseases of the chest at Sunnyside and the Indiana University Medical Center, **Dr. Norman B. Hasler** is now associated with the Parramore Tuberculosis Hospital at Crown Point.

A native of Center Point, **Dr. Charles Moon** has returned there for the general practice of medicine. Following his graduation from the Loyola School of Medicine in Chicago in 1942, he went into active duty with the U. S. Army Reserve Medical Corps. He was released from service in 1946, and since then has been in private practice in Peoria, Illinois.

Dr. Gene S. Pierce has recently opened offices for the general practice of medicine in New Albany. He formerly maintained offices in Wheatland and Monroe City.

Dr. Frederick L. Schoen has returned from a one-year tour of duty with the U. S. Navy to resume his practice with **Drs. N. L. Salon** and **Robert Haller**, at 604 West Wayne Street, in Fort Wayne.

Dr. Robert M. Sherman has resumed the practice of surgery in Bluffton, upon completion of two years postgraduate surgical training at the Christ Hospital in Cincinnati.

Dr. W. M. Taylor, who has been in practice in Crawfordsville for ten years, has moved to Fort Lauderdale, Florida, where he will practice.

Dr. Walter Chroniak, who recently completed a residency in medicine at the Cold Springs VA Hospital, in Indianapolis, has opened an office at 4625 East Tenth Street, in Indianapolis.

A 1950 graduate of Indiana University School of Medicine, **Dr. Herbert E. Baumeister** has opened an office at 3375 Forest Manor, in Indianapolis, for the general practice of medicine. He interned at the Methodist Hospital, in Indianapolis.

Announcement has been made of the association of **Dr. Harlan H. Tyner** with **Dr. E. W. Dyar** in the practice of ophthalmology, at 3202 North Meridian Street, in Indianapolis.

Dr. Robert R. Davies is now associated with the New Castle Clinic, where he will specialize in internal medicine. Following his graduation from the University of Nebraska School of Medicine, in 1947, he spent his internship at Indianapolis General Hospital, and has been in practice at the Indiana University Medical Center and at the Indianapolis Veterans Hospital.

Dr. Paul Elliott, of Indianapolis, has taken over the practice of **Dr. J. W. Gibbs** at Danville. Doctor Gibbs is now a resident physician at the Home Lawn Sanitarium, in Martinsville. Doctor Elliott is a graduate of Indiana University School of Medicine, and spent his internship at Herman Hospital in Houston, Texas. He has also taken postgraduate work in internal medicine at the University of Minnesota.

Dr. Robert W. Gilmore has opened an office with his father, **Dr. Russell A. Gilmore**, in Michigan City. Dr. Robert W. Gilmore will specialize in pediatrics. He is a graduate of the Temple Medical School in Philadelphia, and after serving an internship at Cook County Hospital, spent two years at a Naval Hospital in Cuba. Following this, he served a two-year residency in pediatrics at Cook County Hospital.

Dr. Robert F. Kimbrough has begun the practice of orthopedic surgery as an associate of **Dr. Richard C. Stauffer**, at 347 West Berry Street, in Fort Wayne. A native of Logansport, Doctor Kimbrough is a 1944 graduate of Indiana University School of Medicine, and interned at Indianapolis General Hospital. After serving for two years with the Army Medical Corps, he took three years of orthopedic surgical training at the Mayo Clinic.

Dr. Edgar W. Killian and his wife, **Dr. Camille Hill Killian**, have begun an ophthalmological and otolaryngological practice in Logansport. Dr. Camille Hill Killian, a graduate of the University of Illinois School of Medicine, served a general rotating internship at Wesley Memorial Hospital in Chicago, and has had three years of ophthalmological training. Dr. Edgar W. Killian is a graduate of Loyola University School of Medicine, and served a year of general rotating internship at Cook County Hospital. Following his service with the U. S. Army Medical Corps, he has had three years of otolaryngological training.

Dr. J. H. Clark, of Kendallville, has moved to Big Spring, Texas, where he will be associated with the Cowper Clinic and Hospital.

Dr. William Cripe has opened an office for the general practice of medicine at Redkey. He is a 1950 graduate of Indiana University School of Medicine, and served his internship at the Detroit Receiving Hospital.

Dr. Sam W. Campbell, of Carmel, has moved to Noblesville, where he will practice medicine. He has been in practice in Carmel for three years, following his internship at Indianapolis General Hospital, and two years in the armed services.

Dr. S. Bruce Kephart will specialize in obstetrics and gynecology in Bluffton. A 1943 graduate of the University of Pennsylvania School of Medicine, he spent his internship at the Presbyterian Hospital in Philadelphia, and had specialty training at the Chicago Lying-In Hospital and the City Hospital in Akron, Ohio.

Dr. Howard M. Luginbill, of Berne, has become associated in practice with **Dr. Irvin L. Zeiger** at 3201 Mishawaka Avenue, in South Bend. Doctor Luginbill is a veteran of World War II, and is a graduate of Indiana University School of Medicine. He spent his internship at Memorial Hospital in South Bend.

Upon completion of his residency at Indianapolis General Hospital, **Dr. Foster J. Boyd, Jr.**, has opened an office for the practice of general surgery in Wilmington, Ohio. He is a 1944 graduate of the University of Cincinnati Medical School.

Dr. Reuben Craig has become associated in practice with his father, **Dr. R. A. Craig**, in the Armstrong-Landon Building in Kokomo. The junior Doctor Craig will limit his practice to pediatrics. He is a 1946 graduate of the University of Louisville School of Medicine, and after interning at Indianapolis General Hospital, was senior intern at Babies and Childrens Hospital in Cleveland, and was a teaching fellow in pediatrics at Western Reserve University, in Cleveland.

A.M.A. WASHINGTON OFFICE NEWS

HUMPHREY SUBCOMMITTEE REPORT TO SENATE ON VA MEDICAL CARE

The Humphrey subcommittee of the Senate Committee on Labor and Public Welfare, which has been inquiring into the Veterans Administration medical program since the ouster in January of Chief Medical Director Paul B. Magnuson, reported this week. *The report is highly critical of management of the program by Administrator Carl R. Gray, Jr., but has only praise for Dr. Magnuson.* It sets forth eight recommendations for improving direction of the program and preventing its "complete disintegration."

The report details the growth of the VA medical program under General Omar N. Bradley, VA chief from 1945 to 1948, and former Chief Medical Director Paul R. Hawley and notes the close working relationships developed with the Association of American Medical Colleges, with deans committees and with the profession generally.

Findings in the Gray-Magnuson Dispute

The subcommittee said it found that shortly after General Gray assumed office there was a growing sense of "*uneasiness and distrust*" on the part of the medical profession over a "*vastly different*" relationship between the Administrator and the Chief Medical Director.

Evidence showed General Gray "*most decidedly and personally administered local VA hospital affairs although his predecessor, General Bradley sedulously refrained from so doing.*"

Organizational studies demonstrated General Gray operated under an organizational setup of nine assistant Administrators who appeared to have authority to "*move in on*" *the individual hospital manager and exercise influence*—an "Administrator's nightmare."

It has been proved "conclusively" that under General Gray the previous "basically all-important relationship between the deans of the medical schools, the VA's medical director and the Administrator, which had rested entirely on the confidence which each had expressed in the others, underwent sudden and continuing change."

Policy Agreements by Gray and Boone

General Gray and his new Chief Medical Director, Vice Admiral Joel T. Boone, told the committee they were in agreement on the following points:

1. Appointment of the Chief Medical Director to the committee which selects VA hospital managers. Dr. Magnuson's protest over displacement from the committee was one of the reasons for his ouster.

2. Delegation of final authority to Chief Medical Director for approving attendance at courses of training by VA medical personnel.

3. No hospital construction or alterations will be approved by the Administrator without a joint recommendation of the Chief Medical Director and the Chief of Construction and Supply.

4. Hospital managers shall exercise overall supervision and coordination of all activities and functions of their hospitals.

Recommendations of the Subcommittee

The subcommittee nonetheless bluntly states that it will not be satisfied merely with filing a report. It says: ". . . the current administrative and statutory organization of the Veterans Administration is such that unless both are changed, its medical-care programs may be subjected again and again to the sort of crisis which recently threatened complete destruction and which is anything but dissipated as yet . . . We are herewith recommending to the Administrator and to Congress measures which, in our considered opinion, *should be immediately adopted if the problems confronting the veterans medical-care program are to be resolved and the possibilities of their recurrenee minimized.*"

Proposed Changes in VA Regulations

1. The VA Administrator should formally delegate to the Chief Medical Director such primary authority as may be necessary to assure his effective control over all policy affecting the care and treatment of patients and over the management and operation of the hospital system and this delegation of authority should be clearly and unequivocably set forth.

2. No one shall be appointed manager of a VA hospital without the prior approval of the Chief Medical Director.

3. All "special services" personnel and activities in VA hospitals must be under direct control of hospital managers and operate only in accordance with policies approved by the Department of Medicine and Surgery; furthermore, consideration should be given to abolishing the Office of Assistant Administrator for Special Services, not now under the control of the Medical Director.

4. Budgetary control procedures should be revised, with a view to making the hospital manager responsible for a single budget.

5. Personnel ceiling procedures should be revised, to give the Chief Medical Director more flexibility in the allocation of personnel to hospitals.

The subcommittee says that ". . . *these recommendations should be made effective immediately . . . The threat to the stability of the medical-care program is a clear and present danger which must be met through prompt action.*"

LEGISLATIVE PROPOSALS

1. Public Law 293 (79th Congress) should be amended so as to leave no doubt whatever that the Congress intends the Chief Medical Director to be the principal medical authority of the agency with primary authority to control, manage and operate its medical and hospital program.

2. The law (38 U.S.C.15) should be amended to provide that the Chief Medical Director be appointed by the President with Senate confirmation.

3. Functions of the special medical advisory group to VA (established by P.L.293, 79th Congress) should be realigned to provide for (a) changing the name of the group to the Advisory Commission on Veterans' Medical Care, (b) appointment of commission members by the President, (c) representation on the commission of the public, veterans and "eminent authorities in the respective health professions," including members of the Deans' Committees, (d) continuing review by the commission of VA's medical and hospital program, with a report at least annually to the Administrator and the Chief Medical Director, and (e) regular reports to Congress by the Administrator on the commission's recommendations and his action with respect to them.

Regarding the latter point, the subcommittee states that it is its "*firm conviction . . . that Congress should be advised of the administrative problems when they arise, not after they (are) completely out of control.*"

Army Inducts First Physicians Under Doctor-Draft Law. Army reports drafting of two physicians as privates—the first under the doctor-draft law. Others of the 717 Priority I physicians called up for July presumably received commissions. Army earlier reported marked increases in Priority I men seeking commissions. As a result, Defense Department has asked Selective Service to *delay temporarily the induction of 333 Priority I physicians for August.*

Army first announced drafting of Dr. Stanley J. Orloff of New York City, graduate of Tulane University School of Medicine in 1946. Army said he reported for duty as a private at Camp Kilmer, New Jersey, and is scheduled for assignment to Brooke Army Medical Center at Fort Sam Houston, Texas. Second draftee identified as Dr. Robert Beconovich of Hammond, Indiana, graduate of Indiana University School of Medicine. He reported to Fort Sheridan, Illinois, and then goes to Brooke.

In asking Selective Service to delay August call, Defense Department emphasized its request was based only on the increase in rate of volunteers and not on any reduction of requirements for medical officers. Sustained increase in number of physicians applying for commissions caused the delay. Defense said question of whether calls for September will be made will be settled in the next week. There is *no anticipated reduction in the September call of 152* Priority I physicians, but it's possible that Defense will ask for more men in event the August quota is not filled.

Tax Exemption for Retirement Insurance Premiums for Members of Professional, Business, Agricultural, or Labor Associations. Senator Ives (R.-N.Y.), on the floor of the Senate July 25, explained *an amendment he introduced to the House-passed tax bill* (H.R. 4473). The amendment would, under certain circumstances, exempt from taxation limited premium payments for retirement plans of members of professional and other specified associations—provided such plans have prior approval of the United States Treasury Department. Senator Ives explained such an exemption would correct an unfair situation. He pointed out that it was designed to bring relief to highly educated persons who are not covered by Social Security and who have, after prolonged schooling and training, fewer earning years than the average person now covered by Social Security. He said that lawyers and physicians, for example, do not reach peak earnings until late in life. Physicians, he explained, reach their peak from ten to nineteen years after commencing practice. Increased rates of taxation take dollars from professional persons at a time when they should be setting funds aside for retirement years.

The Ives proposal permits eligible persons to pay each year—tax free—to an approved organization's retirement plan 10% of earned income, or $7,500, whichever is less. Professional, business, and other associations would submit their retirement plans to the United States Treasury Department for approval. To be approved, such plans must provide that premiums could not be withdrawn voluntarily before retirement age (60). The insured, however, could draw benefits before age 60 for total and permanent disability. Upon retirement, the insured or his beneficiaries, could elect to take a lump sum payment or accept annual installments. Under the lump sum payment arrangement, the total amounts would be subject to a capital gains tax not exceeding 25% (present rate). Under yearly installments the insured or his beneficiaries would be subject to regular income tax payments.

Indiana University News Notes

Extensive remodeling is being done in the medical school building, the major operation being the expansion of the medical library. This will make the stacks more accessible for use by the Medical Center staff and doctors throughout the city and state.

The Departments of Medicine of Indiana University, General Hospital and Cold Springs Veterans Hospital are sponsoring conference programs during the summer months. They are presented each Friday evening at 8 p.m. in the classroom of the X-ray Department of the Medical Center with members of the three hospitals staffs alternating in presenting the program.

Dean John D. VanNuys has received from Vice Admiral Joel T. Boone, Chief of the Division of Medicine and Surgery for the Veterans Administration, a request for the School of Medicine to participate, through the Dean's Committee, in the operation of the new VA Hospital and the Cold Springs Road VA Hospital.

Twenty-four new interns began their year of service in the University hospitals on July 1. Thirteen of the group are graduates of the Indiana University School of Medicine, including: Drs. Charles E. Black, John T. Burns, Angeline DeLorenzo, H. K. Gokey, Philip Hershberger, William A. Huston, Richard H. Jowitt, James G. Kidd, John D. MacDougall, Linus J. Minick, Arthur B. Millis, Raymond L. Newnum and Don C. Purnell.

Other new interns and the schools from which they graduated include: Dr. Charles E. Hendrix, Dr. B. J. Bass and Dr. Walter R. Vaughn, Washington University School of Medicine; Dr. Eleanor Clay, Yale University School of Medicine; Dr. E. M. Bremer, University of Wisconsin Medical School; Dr. Harry E. DeHaven, Jr., Johns Hopkins University School of Medicine; Dr. George Gattman, Medical College of South Carolina; Dr. Paul J. LiBassi, Dr. Maura Josephine Lynch and Dr. Louis R. Ziegra, Jr., New York Medical College; Dr. Paul N. Pappas, Ohio State University School of Dentistry.

Twenty-six members of the faculty of the Indiana University School of Medicine have been advanced in academic rank by the Board of Trustees, with the announcement made by President Herman B Wells.

The promotions included the conferring of the title of Professor Emeritus in Proctology on Dr. Joseph W. Ricketts; Professor Emeritus in Genito-Urinary Surgery on Dr. Arthur F. Weyerbacher and Dr. Homer G. Hamer; and the title Associate Professor Emeritus in Pediatrics on Dr. J. Don Miller.

Dr. John L. Arbogast was advanced from Associate Professor to Professor of Clinical Pathology and will continue as Director of the Clinical Laboratories.

Advanced from Assistant Professor to Associate Professor are: Dr. James F. Balch, Dr. Walter P. Morton, Dr. Ernest Rupel and Dr. William N. Wishard, Jr., in Genito-Urinary Surgery; Dr. L. W. Freeman in Surgery; Dr. Virgil K. Stoelting in Anesthesia; and Miss Lute Troutt in Dietetics.

Promoted from Instructor to Assistant Professor are: Dr. J. Neill Garber, Orthopedic Surgery; Dr. John P. Graf, Anesthesia; Dr. Ralph G. Wilmore, Clinical Medicine; and Miss Louise Irwin, Dietetics.

Advanced from Associate to Assistant Professor are: Dr. Evart M. Beck, Dr. William D. Gambill, Dr. Laura Hare, Dr. Joseph E. Tether, Dr. E. Paul Tischer and Dr. Helen VanVactor, all in Medicine; Dr. George M. Brother in Public Health; Dr. Robert D. Howell and Dr. John W. Hendricks in Genito-Urinary Surgery.

Dr. Carl D. Martz in Orthopedic Surgery and Mr. Robert Yoho in Public Health, were promoted from Associate to Instructor; while Dr. Thomas Brady and Dr. Robert Kinzel were advanced from Assistant to Associate in Orthopedic Surgery, and Dr. Wayne Carson was advanced from Assistant to Associate in Surgery. The additional title of 'Cancer Coordinator' was conferred on Dr. E. A. Lawrence.

Alumni Day of the School of Medicine will be observed in 1952 on Wednesday, May 14. The date for the fifth annual reunion was selected at the recent meeting of the officers and council of the Alumni Association.

Mr. Elton T. Ridley began the first of July a year of duty on the Medical Center campus as an Administrative Resident. A native of Chicago and a veteran, Mr. Ridley has been a student in hospital administration at the University of Chicago. Mr. Bernard Carr, who has completed a year as an Administrative Resident, has been named an Administrative Assistant.

Three members of last year's intern staff are entering the general practice of medicine: Dr. Edwin E. Stumpf is located at New Haven; Dr. Merritt O. Alcorn, Jr., is starting practice at Madison, and Dr. William A. Kleinfgen is in general practice at Fort Wayne. Dr. Ralph Streeter and Dr. Argyl Bacon are entering the Army Medical Corps with Dr. Streeter assigned to the hospital at Camp Atterbury.

The 'Quarter System' for senior medical students was inaugurated last month with approximately one-fourth of the class remaining on the campus during the summer months. Each senior elects the three quarters which he attends and during the fourth quarter is free to take special work or to accept income-producing employment.

The plan, enthusiastically accepted by the students, also meets the teaching problem resulting from the large classes in limited classroom, laboratory and clinic facilities.

Advanced by the Indiana University Board of Trustees to fill vacancies in departmental chairmanships were Dr. Marlow W. Manion, named Profesor of Otolaryngology and Chairman of the Department of Otorhinolaryngology and Broncho-Esophagology, and Dr. Lyman T. Meiks, named Chairman of the Department of Pediatrics and Professor of Pediatrics.

Doctor Manion, a graduate of the School of Medicine and a member of the staff for the past 21 years, succeeds Dr. Carl H. McCaskey who retired a year ago after 29 years on the faculty, 15 of them as head of the department. Doctor Manion is a member of the Indianapolis, Indiana and American Medical Associations; a Diplomate of the American Board of Otolaryngology and a member of the American Triological Association and the American Broncho-Esophagological Association.

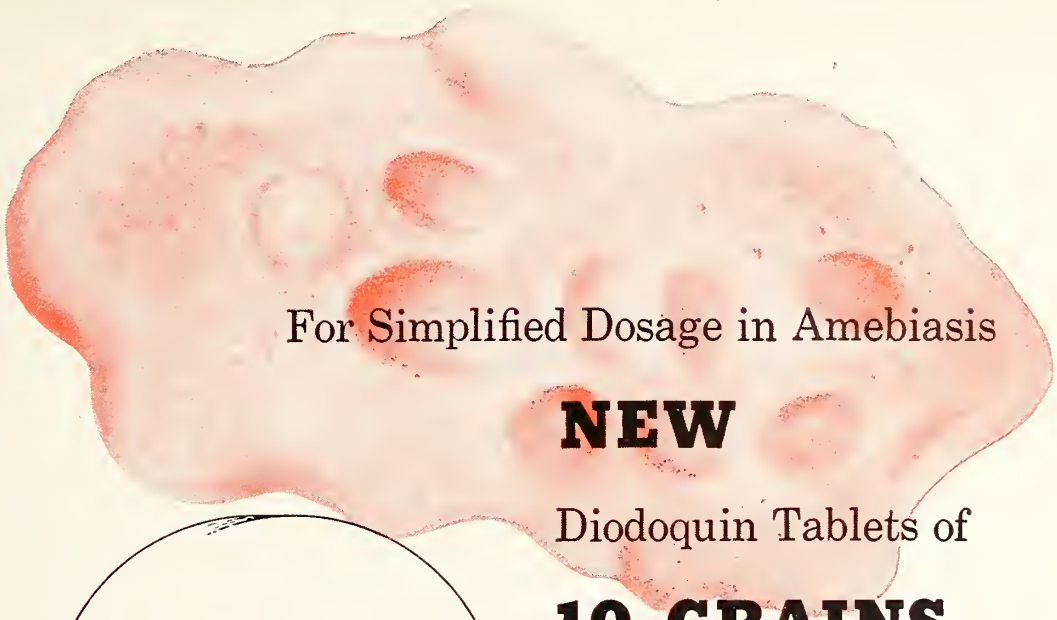
Doctor Meiks succeeds Dr. Matthew Winters as Chairman of the Department of Pediatrics, a post which Doctor Winters had filled with distinction for 20 years. Doctor Meiks, a graduate of Johns Hopkins School of Medicine, has been a member of the I. U. Medical School staff since 1931 and has served as full-time pediatrician at James Whitcomb Riley Hospital for Children. He is a Diplomate of the American Academy of Pediatrics; a member of the American Academy of Pediatrics and the American Pediatric Society as well as the Indianapolis, Indiana and American Medical Associations.

Announcement is also made of the appointment of Dr. Edward B. Smith to the staff of the School of Medicine with the rank of Professor of Pathology. Doctor Smith is a native Hoosier, born at Petersburg, and attended Hanover College before enrolling at Indiana University where he received his B. S. and M. D. degrees. His intern and residency training were in Cleveland hospitals and he served for two years as an Instructor in Pathology at Washington University, St. Louis, before entering the Army Medical Corps in 1942. After leaving the Army in 1946, Doctor Smith was on the pathology staffs of the University of Pennsylvania and Baylor Medical College before returning to Washington University in 1949 as Assistant Professor of Pathology.

A Diplomate of the American Board of Pathology in Pathogenic Anatomy and Clinical Pathology, Doctor Smith is also a member of the American Association of Pathologists and Bacteriologists, the American Association of Clinical Pathologists, a Fellow of the College of American Pathologists, a member of the Board of Governors of the International Association of Medical Museums, and vice-president of the St. Louis Pathologic Society.

Doctor Smith is author of a number of articles dealing with pathology and is widely known for his work in the field of cancer. He was one of the speakers at the Malignant Disease Symposium held at the Medical School earlier this year, which drew a large number of Indiana physicians.

The Instructional Courses of the 1951 Session will present discussions of "Obstetrical Emergencies," "The Management of Diabetes Mellitus," "Office Diagnosis and Treatment of Common Genitourinary Conditions," and "The Psychological Management of Patients."



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SEARLE **RESEARCH IN THE SERVICE OF MEDICINE**

Deaths

George H. McCaskey, M.D., of Winamac, brother of Dr. C. H. McCaskey, of Indianapolis, died on July 25, at the age of sixty-four. A graduate of Indiana University School of Medicine, in 1911, Doctor McCaskey practiced first at West Newton, then moved to Winamac in 1924, where he had practiced ever since. He was a member of the Pulaski County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Maro F. Hunn, M.D., of Elkhart, died on July 5, after an illness of two years. He was seventy-one years of age. A graduate of the University of Michigan Medical School, in Ann Arbor, in 1904, Doctor Hunn had practiced in Shipshewana before going to Elkhart to practice, where he remained for the past twenty-eight years. He was a member of the Elkhart County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

John H. Jackson, M.D., who had practiced in Pleasantville for forty-seven years, died on July 31, at the age of eighty-five. He was a graduate of the Louisville Medical College, in Louisville, in 1894, and began practice in Pleasantville.

Benjamin P. Linvill, M.D., of Columbia City, died on July 7, at the age of sixty-nine. He was a graduate of the University of Michigan School of Medicine, at Ann Arbor, in 1909.

William E. Nichols, M.D., retired physician of Hammond, died on July 21, at the age of seventy-nine. A graduate of Rush Medical College, in Chicago, in 1894, he practiced in Terre Haute for more than twenty years, before moving to Hammond. Doctor Nichols was an Honorary member of the Lake County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Lewis N. Ashworth, M.D., of Connersville, died on August 3, after an illness of several months. He was fifty-five years of age. A 1925 graduate of Indiana University School of Medicine, he served with the U. S. Base Hospital 32 in World War I, and then returned to Connersville to practice. Doctor Ashworth was a member of the Fayette-Franklin County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Stephen C. Alexander, M.D., of New Albany, died on July 27 after a long illness. He was seventy-two years of age. He was a 1903 graduate of the Medical College of Indiana, in Indianapolis.

Thomas J. Dugan, Jr., M.D., formerly of Indianapolis, died in Silver Spring, Maryland, on July 17, at the age of forty-three. He was the son of Dr. Thomas J. Dugan, of Indianapolis. He graduated from the George Washington University School of Medicine, in Washington, in 1936, and was a veteran of World War II.

The schedule of courses and the order blank for tickets for the Instructional Courses is on page 859 of this issue.



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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

July 15, 1951

The Council of the Indiana State Medical Association convened for its summer meeting at 10:10 a.m., daylight saving time, Sunday, July 15, 1951, in the Harrison Room of the Columbia Club, Indianapolis, with Dr. W. U. Kennedy, chairman, presiding. Roll call showed the following present:

Councilors:

First District	Paul D. Crimm, Evansville, alternate
Second District	William C. Reed, Bloomington, Sam I. Rotman, Jasonville, alternate; A. G. Blazey, Washington, councilor-elect
Third District	William H. Garner, New Albany
Fourth District	Charles Overpeck, Greensburg
Fifth District	A. M. Mitchell, Terre Haute V. Earle Wiseman, Greencastle, alternate; M. C. Topping, Terre Haute, councilor-elect
Sixth District	W. U. Kennedy, New Castle
Seventh District	Roy A. Geider, Indianapolis Don E. Wood, Indianapolis, alternate, and co-chairman, Legislative Committee
Eighth District	E. H. Clauser, Muncie F. E. Keeling, Portland, councilor-elect
Ninth District	Wemple Dodds, Crawfordsville Harry E. Klepinger, Lafayette, alternate
Tenth District	William H. Howard, Hammond
Eleventh District	Elton R. Clarke, Kokomo
Twelfth District	M. B. Catlett, Fort Wayne
Thirteenth District	Not represented

Officers:

Alfred Ellison, South Bend, president.
J. William Wright, Indianapolis, president-elect.
Roy V. Myers, Indianapolis, treasurer.
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL.
Walter L. Portteus, Franklin, chairman, Executive Committee.
C. J. Clark, Indianapolis, member, Executive Committee.

A.M.A. Delegates and Alternates:

F. S. Crockett, Lafayette.
H. G. Hamer, Indianapolis.
E. S. Jones, Hammond.

Guests:

J. Neill Garber, Indianapolis, chairman, Committee on Convention Arrangements.
James W. Denny, Indianapolis, chairman, Committee on Medical Education and Hospitals.
Albert Stump, Indianapolis, attorney.
Ray E. Smith, Indianapolis, executive secretary.
James A. Waggener, Franklin, field secretary.

On motion of Drs. Mitchell and Clarke, the minutes of the April 29, 1951, meeting of the Council, held at Indianapolis, were approved as printed in the June, 1951, issue of THE JOURNAL.

At this time Councilors-elect Blazey, Topping and Keeling, who will take office January 1, 1952, were introduced.

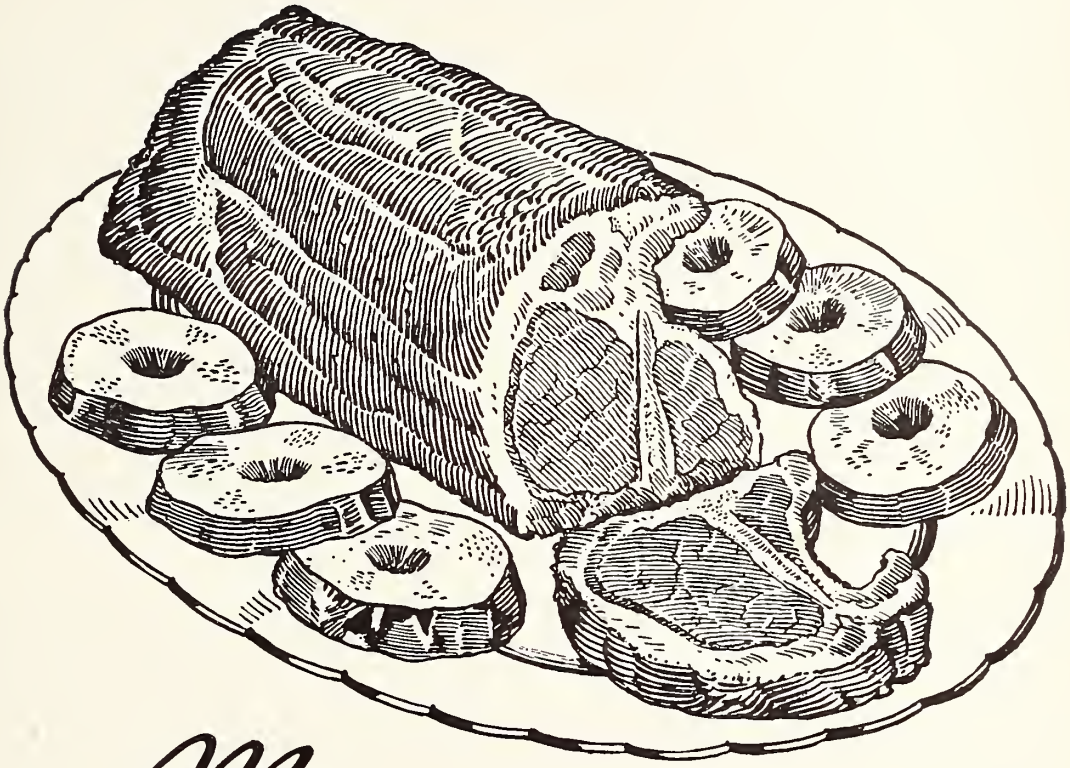
REPORTS OF COUNCILORS

Doctor Clauser spoke of the strike of non-professional workers at the Ball Memorial Hospital, Muncie. Following discussion by Drs. Portteus, Clauser, Clarke, Howard and Mitchell, on motion of Drs. Howard and Clarke the Council approved the creation of a committee of three to bring in a report in the name of the association for publication. The chairman appointed Drs. Clauser, Catlett and Clarke as members of this committee.

REPORTS OF OFFICERS

Dr. Alfred Ellison, president, 1951: "I am glad to tell you that we believe everything is going along about as well as we can expect. There is a fly in the ointment here and there, but we will always have them, I am sure. But I think that during this year we have awakened an interest out among the doctors in the state in organized medicine, and I think that that's finally going to result in a lot of good. During the month of May there were eleven district meetings, as you probably realize, and in addition to those, there were four state division meetings, sponsored by the Rural Health Committee—one at Madison, one at Lafayette, one at Muncie and one at Elkhart, making a total of fifteen meetings in May. I should report to you that Doctor Wright was very active and faithful in getting around to these meetings. Ray, of course, and Jim were there.

"Now, growing out of some of these meetings we have come by some information that this Council ought to take recognition of. We heard at various places that the doctors over the state believe that the doctors in the local communities should be a little bit nearer to organized medicine in the state, bringing them into the picture a little closer. I think, as far as our internal public relations in the organization are concerned, that we would do very well to consider the proposition that I want to suggest to you now. We hear among the men that the Council meets and does certain things and that the local county societies have little influence or knowledge about these things that they discuss and talk about, and they feel a little out of the picture, and, because of that, they lose interest in the state organization. I personally feel that that is justified. I can well remember when I was a councilor that even though I was supposed by the by-laws to visit each of the



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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (Apr. 2,) 1949

American Meat Institute

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counties ever so often that I wasn't too faithful about it. Now, I am inclined to believe that that's true of most of the councilors. There are some that do get around, I think, rather frequently, but I think it is more or less of an exception. Now, the thing that I would like to propose to you, the thing that I would like to see instituted as a form and part of our obligations, perhaps become a part of the by-laws, would be this: to have the proposed agenda for each of the four councilor meetings prepared well in advance and have a stated meeting, perhaps two weeks prior to the Council meeting in each of the districts, a stated meeting held by the councilor, to which he would invite all the county presidents and secretaries for the purpose of going over this agenda with them and getting their reactions to these matters that are to be discussed and decided. Now, that's going to do a tremendous good. It's going to make these men in the first place realize that we are truly democratic in this thing. There isn't a man here who doesn't want to be democratic about it. In the second place, we are going to get some information, grass roots thinking, that is going to improve our progress. I would like to see somebody initiate a motion to bring this sort of a plan into effect . . . Somebody says it's going to mean a lot of work. I agree that that is true, but the substance of it is that if we are not willing to do this job, let's let somebody else do it."

Dr. J. William Wright, president-elect: "I just want to emphasize one particular thing that Judge mentioned. It has been a pleasure for me to visit some of these district societies this year, and I think that any man who accepts the responsibility of being a councilor should feel that it is his duty to visit his societies in his district. If we are going to get any place in organizing medicine, in keeping together, we certainly are going to have to do it by sacrificing a little time, and I believe it is the duty of every councilor to visit his societies to see what is going on and create a good feeling."

On motion of Drs. Mitchell and Crimm, the Council accepted and adopted Doctor Ellison's proposal, and instructed that it be carried out as soon as it can possibly be done.

Dr. Ellison: "There is another matter that was brought to the attention of the Executive Committee last night, and, in view of the fact that it indicates a trend that we believe is going on and is gaining momentum, we feel that the Council should take recognition of this situation also, and we hope take some action in regard to it. I refer to the continuous reports we receive regarding a few members of our organization who are overcharging the public or in other ways mistreating them. If these men are to continue as members of the state organization it seems to me that we have a moral obligation not only to ourselves and to the public, but a moral obligation to the doctors who are to follow us, to do something about this trend. The Physician-Patient Relations Committee as it is now constituted has no power to act in these cases. Some of our larger county societies are doing an excellent job of bringing the occasional physician who mistreats the public before their respective grievance committees. But we must remember that this requires an unusual interest on the part of the local society officials, and we must remember too that in our smaller county society groups it is not reasonable to expect these deflections to be handled adequately by fellow doctors who, in such cases, are so intimately associated with the offender. In a small group it is human nature to avoid the unpleasantness associated with such a problem. It is becoming more apparent with the passage of time that these derelictions on the part of a small percentage of our members must be definitely dealt with because the damage they are doing to the reputation of all doctors and to our system of medical practice will soon be irreparable.

"At the present time our Physician-Patient Relations Committee must be composed of ex-presidents, in accordance with the action of the House of Delegates. It must be recognized that the number of ex-presidents is limited. Moreover, they are frequently past the age where they have the desire or spirit to take part in the unpleasant obligations involved in such committee membership. We are immediately hindering our objectives when we limit membership on this committee to ex-presidents. I strongly recommend that our regulations concerning this Physician-Patient Relations Committee be changed so that the committee may be drawn from the membership at large. Moreover, this committee should be equipped with authority to take appropriate action in such cases as are brought to its attention. This is a matter of prime importance and the responsibility is yours to recommend to the House of Delegates the correction of this system."

Following discussion by Drs. Kennedy, Howard and Garner, on motion of Drs. Mitchell and Howard the Council voted to recommend to the House of Delegates that the by-laws be revamped in order that grievance problems may be more adequately handled. The motion provided also for the appointment of a committee from the Council to formulate the procedure to be used in grievance cases, and a copy of the committee's recommendations is to be placed in the hands of each delegate thirty days prior to the 1951 annual convention. The committee appointed by the chairman of the Council to consider this matter consists of Drs. Howard, Reed and Geider.

(Continued on page 876)

BELIEVE IN YOURSELF!

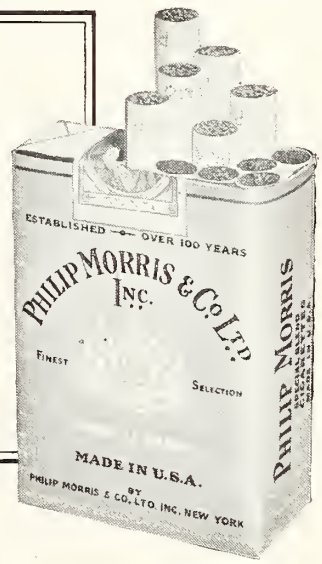
Doctor, you probably have read a great deal of cigarette advertising with all sorts of claims.

So we suggest: make this simple test...

Take a PHILIP MORRIS—and *any* other cigarette. Then,

1. Light up either one. Take a puff—don't inhale—and s-l-o-w-l-y let the smoke come through your nose.

2. Now do exactly the same thing with the other cigarette.



Then, Doctor, BELIEVE IN YOURSELF!

PHILIP MORRIS

Philip Morris & Co. Ltd., Inc.
100 Park Avenue, New York 17, N. Y.

(Continued from page 874)

UNFINISHED BUSINESS

1. *Contribution to American Medical Education Foundation.* Doctor Denny, chairman, Committee on Medical Education and Hospitals, presented the following arguments for contributions from individuals rather than from the state association funds to the American Medical Education Foundation:

a. If a man contributes individually he becomes more interested in medical schools and medical education.

b. Individuals can designate to which school their contributions shall go; the state association cannot specify.

On motion of Drs. Mitchell and Howard, the Council authorized the Committee on Medical Education and Hospitals to assume the responsibility of promoting the campaign to collect funds for medical schools from Indiana physicians on an individual basis and not from the state level.

2. *The American Way, Inc.* In the absence of Dr. Herman Combs, Doctor Crimm presented the following paper on The American Way, Inc., of Evansville, as requested by the Council at its April 29, 1951, meeting:

The American Way, Inc.

The American Way, Inc., is a group of local citizens banded together for an expression of informed public opinion for the promotion of American freedom and rights. The membership of the organization includes people in all fields of work and activity in American life. It is not a pressure group, but one that intends to inform the public of American principles by the proper use of freedom of speech in behalf of worthwhile opinions.

Many people take the view that the complex affairs of government and legislative action are hopelessly beyond any point of the individual's influence. People complain of trends and ideologies that are foreign to the American way. Mounting taxes, careless spending, red tape, duplication of authority, lack of business methods and ethics, and an obvious unconcern for the will of the people—these are some of the aspects of governmental administration that are criticized. The American Way, Inc., takes the stand that something can be done about the conditions.

By discussion and expression with friends, associates, public officials, candidates, and others interested in good government, important opinions can be brought out into the open for public study. As taxpayers, all of us are stockholders in a community, a state, and a national government. As citizens, all of us are involved with the well-being and happiness of those who live about us. To the membership of the American Way, Inc., these facts seem to rise above the demands and desires of special groups and misguided individuals. There's an American way to do things—and now is the time to be about that business! Our country has become, and is, the greatest the world has ever known by cherishing democracy as an ideal and by practicing democracy as a daily way of life.

Significant Aims of the American Way, Inc.

(1) To support a way of living that is specifically American. This we interpret as being a way of life that provides each individual with better food, clothing, shelter, and education, and which guarantees personal liberty and genuine opportunity to a degree that does not exist in any other nation on earth.

(2) To plan and work for such desirable gains in health, housing welfare and security legislation as are actually needed and for which we, as taxpayers, can pay without hardships and loss of our cherished rights as American citizens.

(3) To strive for practical reduction in taxes and to condemn waste, extravagant spending, and insincerities by our elected governmental bodies, whether local, state, or national. From these actions we hope to lessen the deductions now made from our earnings.

(4) To oppose governmental regulations and practices which are adverse to honest enterprise and initiative; and to work against legislative controls which are unnecessary to the common good and which provide questionable privileges to special groups and classes.

(5) To encourage by publicity and educational endeavor the wide understanding of American inheritances and rights. To defend American freedom to vote, to speak, to worship, to work, and to live where one pleases.

(6) To keep the community informed about the legislative proposals, opinions, and records of all candidates for elective office. To urge all citizens in our community to vote in every election.

(7) To accept the responsibilities of good citizenship at all times and to provide the facilities and resources of an organization devoted to the American way for the benefit of citizen, community, and country.

The physicians of Vanderburgh County were especially interested in the foregoing aims of this nonpartisan organization because we are concerned not only in keeping socialism out of the medical profession, but also in keeping socialism out of labor, business, agriculture and industry. Furthermore, we want to ostracize socialistic planks out of the platforms of both the Democratic and Republican parties. During recent years the socialistic wing of one of our two most reputable political parties has been in control of said party.

(Continued on page 878)



Baker's Modified Milk



Powder and Liquid

Made from Grode A Milk

because: Baker's meets their requirements for most bottle-feeding cases—either complemental to, or entirely in place of mother's milk. With Baker's no formula change is required as baby grows older — merely increase the quantity of each feeding.

To put your babies on Baker's just leave instructions at the hospital. Write for complete descriptive folder.

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC.

Main Office: Clevelond, Ohio
Plont: East Troy, Wisconsin

Division Offices: Son Francisco, Los Angeles, Dollas, Denver, Seattle and Greensboro, N. C.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

(Continued from page 876)

Organizations like The American Way, Inc., can do much toward enlightening the voter regarding the socialistic tendency of any particular candidate for office.

We are likewise interested in changing the views of socialistic-minded men and women in Public Health Associations, the Tuberculosis Associations, Community Chests, the Red Cross, and so on down the line. During recent years all of these organizations have hired professional workers who lean toward left-wing thinking, either wittingly or unwittingly. It is astonishing to see boards of directors of these state and local organizations violently oppose national socialism, yet they cannot recognize the socialistic training and tendencies in their own executive directors and secretaries.

In the last election, The American Way, Inc., in Vanderburgh County published a Voter's Guide, which gave the records and views of the candidates in both major political parties. They have also published a Voter's Guide for the coming local election. The publishing of such a guide for a local election is of questionable value, because of the expense involved and because our local newspapers are publishing the same records. Why publish the records of all local candidates in any election, since socialistic legislation lies in the hands of those men who are elected to our state and national legislatures? If organizations like The American Way, Inc., are successful in electing to the legislatures leaders who are opposed to economic slavery, certainly anyone who expects to run locally in the future for such an office will be guided by the results obtained in defeating candidates with pink tendencies.

As to finances, it is much easier to obtain money for an organization of this character prior to national campaigns than it is prior to local campaigns. It is much easier to obtain memberships prior to a national campaign than it is before a local campaign, since a great many people do not wish to become involved publicly in local political affairs.

If you run an administrative office for an organization like The American Way the year round it will cost from ten to twelve thousand dollars a year in a city like Evansville. If the office is operated just four or five months prior to a national campaign the organization can be operated on a more economical basis, since interim meetings can be held without the services of a full-time director. The American Way in Evansville charged a $1.00 fee for membership, but the organization lived on money from large contributors. Just recently they are changing the dues to $5.00 for a family membership.

In the last analysis the success of such an organization is how the entire county, townships and precincts are organized for the election in getting out the vote. Another secret to the success of such an organization is to have a director who is a goood salesman and organizer. Again, it is easy to weaken such an organization if they do not stick to the aims of the organization. One can be side-tracked by a lot of inconsequential details and crack-pot ideas in such a democratic organization.

The success of any organization like The American Way, Inc., is directly proportional to the amount of apathy which exists among its membership. The apathy which exists in the American public today is very difficult to remedy. Lethargic patriotism is partly responsible for the apathy of the American citizen and this apathy will continue until we obtain honest and courageous leadership, the kind of leadership which our Government leaders possessed in the days of 1776.

1951 ANNUAL SESSION AT INDIANAPOLIS

Doctor Garber, chairman of the Committee on Convention Arrangements, presented detailed plans and estimated costs for entertainment. At his request, and on motion of Drs. Catlett and Geider, the Council voted a budget of $5,000 to the Committee on Convention Arrangements for 1951 convention entertainment.

MEMBERSHIP MATTERS

Remission of state dues. On motion of Drs. Howard and Catlett, the Council voted to remit the dues of three physicians who had been certified by their county medical society secretaries.

NEW BUSINESS

1. *Report on Atlantic City AMA annual session.* Doctor Hamer, delegate, presented a detailed resumé of the actions taken by the House of Delegates during the Atlantic City session. (Complete report published in August, 1951, issue of THE JOURNAL).

2. *Legislative matters.* Doctor Wood, co-chairman of the Committee on Public Policy and Legislation, reported briefly on the status of national legislation and the importance of counteracting socialistic tendencies of today.

3. *Matters referred to Council by Executive Committee:*

a. *Scholarship problems.* Doctor Portteus, chairman of Executive Committee, read from the minutes of the June 24 meeting of that committee:

"On motion of Drs. Clark and Ellison the Executive Committee is to recommend to the Council that the Council recommend to the House of Delegates that the student loan fund which replaced the medical and nursing school scholarships be discontinued."

Doctor Portteus explained that this action was taken in view of the unfavorable results accomplished by the scholarships awarded.

(Continued on page 880)

for the **ULCER PATIENT...**

DOUBLE COMFORT



PROMPT, PROLONGED PAIN RELIEF **WITHOUT ACID REBOUND**

CHART LEGEND
The tablet material (2 gm. equivalent to 30.8 grains Doraxamin) was added to 150 cc. artificial gastric juice and stirred at 37 degrees C. Every 10 minutes there was removed 20 cc. of the mixture which was replaced by 20 cc. of fresh artificial gastric juice. At regular intervals the pH of the mixture was determined with a Beckman pH meter.

FOR THE TREATMENT of peptic ulcer and hyperacidity, the market has long afforded neutralizing agents which are satisfactory to a degree. Frequently, however, a dosage sufficient for prompt, lasting pain relief brings in its wake a discouraging acid rebound.

Doraxamin brand of dihydroxy aluminum aminoacetate rules out this reaction. Because it is a chemical combination of aluminum with glycine, one of the amino acids, it provides both rapid acid neutralization by the amino acid and a secondary prolonged buffering of acid by the decomposition of the aluminum salt of the glycine.

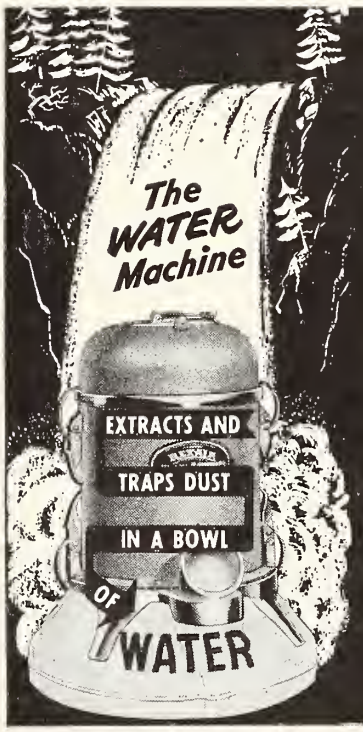
Doraxamin raises the pH of artificial gastric juice to approximately 3.9 in ten minutes, and maintains a pH of above 3.0 for two hours. Repeated tests have shown conclusively that, even when Doraxamin is given in excess, the pH never reaches a maximum of more than 4.5. There is, therefore, no danger of alkalosis and no acid rebound.

References:

1 Krantz, Kibler and Bell: "The Neutralization of Gastric Acidity with Basic Aluminum Aminoacetate," J. Pharmacol. and Exper. Therap., 82:247 (1944).
2 Paul, W. D., and Rhomberg, C.: "Medical Management of Uncomplicated Peptic Ulcer," J. Iowa M. Soc. 35:167-85 (1945).
3 Holbert, J. M., Noble, Nancy, and Grote, I. W.: J.A.Ph.A., Scientific Edition, 36:149 (1947).
4 Holbert, J. M., Noble, Nancy, and Grote, I.W.: J.A.Ph.A., Scientific Edition, 37:292-294 (1948).

TABLETS
Doraxamin
BRAND OF DIHYDROXY ALUMINUM AMINOACETATE

SMITH-DORSEY *Division of the Wander Company*
LINCOLN, NEBRASKA • DALLAS • LOS ANGELES • MEMPHIS



Rexair Traps Household Dust in Water

WASHES AIR, HUMIDIFIES, VAPORIZES, DOES ALL VACUUM CLEANING WORK, AND EVEN SCRUBS FLOORS!

Water is the secret of Rexair's dust-filtering action. Rexair—and only Rexair—passes the stream of dust-filled air completely through a churning bath of water, discharging clean, humidified air into the room. Rexair direct factory sales and service branches are listed in phone books of principal cities of United States and Canada. Call your local branch or write direct to:

REXAIR DIVISION, Martin-Parry Corporation
Box 964 MG 91 TOLEDO, OHIO

EXCLUSIVE WITH Rexair
Fully Guaranteed by a 69-Year-Old Company
OVER 1,000,000 SATISFIED USERS

Head Pain as a Diagnostic Lead

Frequently the presence of head pain is overlooked. The physician learns of it only if he has made an effort to elicit the information. Since the etiology of the pain is the basis of rational management, the patient should be warned against taking medication before diagnosis is made.

Friedman[1] deplores the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache — its character, laterality, frequency and intensity.[2]

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic, analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain not related to b.p. level; Dihydroergotamine. relieves pain.	General hypertension therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g-i. upset during headache.	To abort attack: oral ergotamine plus caffeine. General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,[3] and Friedman, A. P.[4]

Cecil[5] ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

1) Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.

2) Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.[1,6] The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 54:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563; Saunders Co., Phila. 5. Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, NEW YORK

(Continued from page 878)

On motion of Drs. Howard and Mitchell, the Council concurred in the action of the Executive Committee in this matter.

b. *Indiana Foundation for Health.* Doctor Portteus read the minutes of the June 24 meeting of the Executive Committee, as follows:

"After the proposed by-laws of the Indiana Foundation for Health were explained by the chairman of the Committee on Rural Health they were approved on motion of Drs. Kennedy and Clark. On motion of Drs. Kennedy and Ellison, a recommendation is to be made to the Council that $5,000 be appropriated for the association's participation the first year, providing other participating organizations contribute proportionate amounts."

On motion of Drs. Clarke and Crimm the Council is to make the above recommendation to the House of Delegates.

There being no further business, the Council adjourned to meet again at 11:00 a.m., Monday, October 29, 1951, in the Athenaeum, Indianapolis.

EXECUTIVE COMMITTEE

July 14, 1951.

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; Alfred Ellison, M.D.; J. William Wright, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guest: R. E. Jewett, M.D., secretary, Committee on Maternal and Child Health.

Statements of receipts and expenditures and report on the budget for June for the association and THE JOURNAL were approved.

Membership Report

Number of members July 13, 1951	3,546*
Number of members July 13, 1950	3,595
Loss over last year	49
Number of members December 31, 1950	3,689

*Includes 46 in military service (gratis)
135—$10.00 members (residents and interns)
205—senior members
32—members, dues remitted by Council

Number who have paid 1951 AMA dues	2,807
Number who paid 1950 AMA dues	2,843

Treasurer's Office

On motion of Drs. Clark and Wright, the treasurer was instructed to re-invest $4,000.00 from matured City Hospital bonds in bonds which are guaranteed by the Federal Insurance Deposit Corporation, and which bear 3 percent interest.

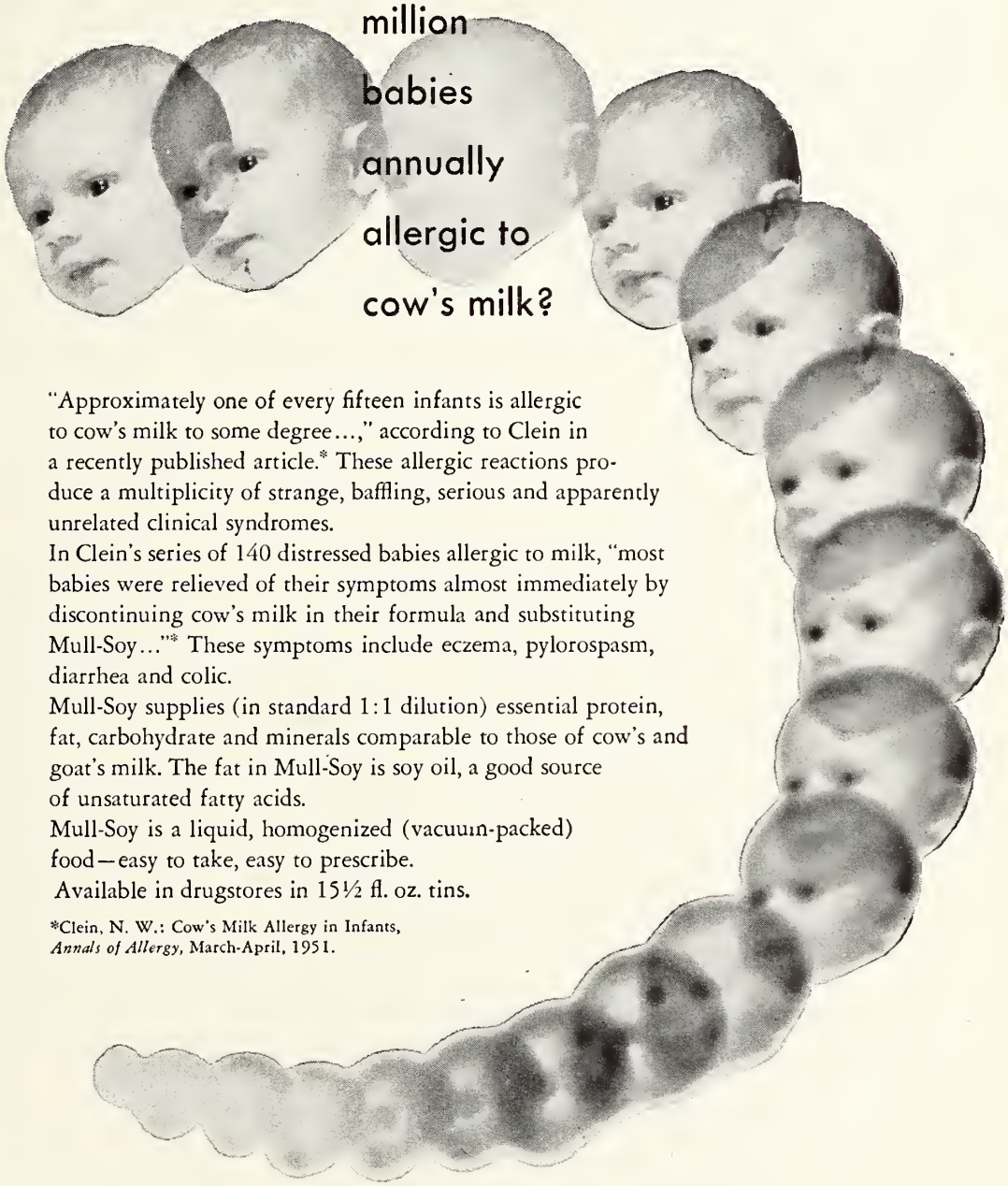
1951 Annual Session, Indianapolis, October 29, 30 and 31, 1951

Technical exhibit

Restrictions on exhibits. On motion of Drs. Kennedy and Wright the Executive Committee

(Continued on page 882)

almost a quarter million babies annually allergic to cow's milk?



"Approximately one of every fifteen infants is allergic to cow's milk to some degree...," according to Clein in a recently published article.* These allergic reactions produce a multiplicity of strange, baffling, serious and apparently unrelated clinical syndromes.

In Clein's series of 140 distressed babies allergic to milk, "most babies were relieved of their symptoms almost immediately by discontinuing cow's milk in their formula and substituting Mull-Soy..."* These symptoms include eczema, pylorospasm, diarrhea and colic.

Mull-Soy supplies (in standard 1:1 dilution) essential protein, fat, carbohydrate and minerals comparable to those of cow's and goat's milk. The fat in Mull-Soy is soy oil, a good source of unsaturated fatty acids.

Mull-Soy is a liquid, homogenized (vacuum-packed) food—easy to take, easy to prescribe.

Available in drugstores in 15½ fl. oz. tins.

*Clein, N. W.: Cow's Milk Allergy in Infants, *Annals of Allergy*, March-April, 1951.

Mull-Soy

first in

hypoallergenic diets for infants, children and adults

The **Borden** Company, Prescription Products Division, 350 Madison Avenue, New York 17



The Know-How in Treating the

PROBLEM DRINKER

The Keeley Institute is more than a group of buildings.

The laboratory, dining room, examining rooms, gymnasium, physical therapy and other departments are manned by trained and experienced personnel.

It is the combination of *know-how* and physical facilities which accounts for the eminent success of the treatment of alcoholism at The Keeley Institute.

Information, including rates, will be furnished to physicians on request.

The **KEELEY** *Institute*

DWIGHT, ILLINOIS

(Continued from page 880)

adopted the following rules for companies who exhibit at the 1952 and subsequent annual sessions:

Exhibits must in every respect conform to the following requirements:

Pharmaceutical and allied products: All such products exhibited must stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

Foods (Special-Purpose): Must have acceptance of the Council on Foods and Nutrition of the A.M.A.

Physical Therapy Devices and Diagnostic Equipment: Must have acceptance of the Council on Physical Medicine and Rehabilitation of the A.M.A.

No medical journal or publication will be permitted to be exhibited if it contains advertising of drugs, chemicals or any therapeutic agents which do not conform to the requirements of the Councils and Committees of the American Medical Association.

The Indiana State Medical Association reserves the right to restrict any exhibit which might be considered undesirable. This restriction includes articles, conduct, printed matter, or anything objectionable to the exhibit as a whole.

Organization Matters

Cesarean section rates in Indiana hospitals. After Doctor Jewett explained the desire of the Committee on Maternal and Child Health to publish the percentage of Cesarean sections in Indiana hospitals in THE JOURNAL, the committee's action was approved, on motion of Drs. Clark and Kennedy.

Indiana Committee on National Doctors Committee for Improved Federal Medical Services. The president was authorized to appoint an Indiana chairman for the National Doctors Committee for Improved Federal Medical Services, on motion of Drs. Wright and Clark.

Health examinations of prostitutes. On motion of Drs. Wright and Clark, the executive secretary was instructed to send a copy of a letter from the American Medical Association concerning health examinations of prostitutes to the secretary of the Tippecanoe County Medical Society.

The Journal

Report on advertising:

July, 1951	$3,027.21
July, 1950	2,564.80
Gain	$ 462.41

On motion of Drs. Ellison and Wright the committee voted against publishing Dow Theory Forecasts in THE JOURNAL.

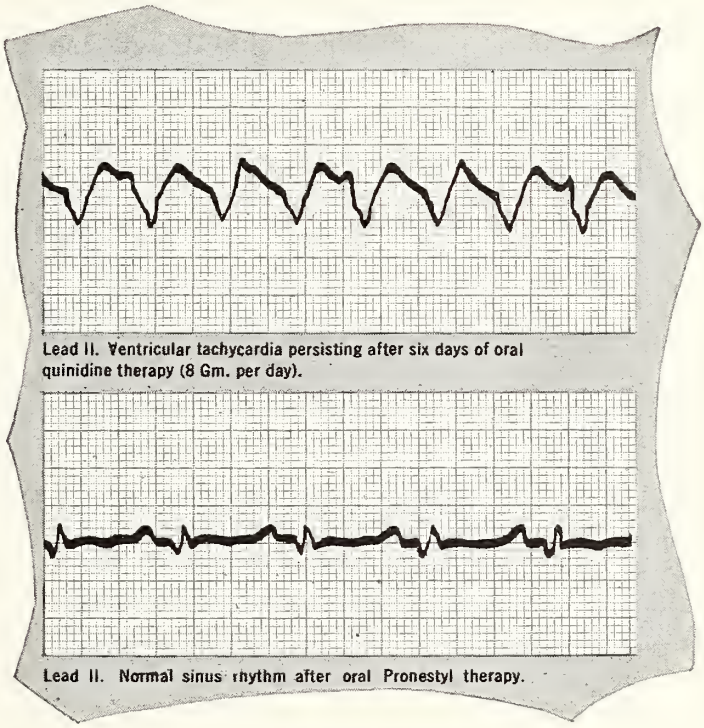
There being no further business, the committee adjourned to meet again on Sunday, September 23, 1951, at 10:00 a.m., at the Columbia Club, Indianapolis.

a new drug . . .

for the treatment of ventricular arrhythmias

PRONESTYL *Hydrochloride*

Squibb Procaine Amide Hydrochloride



Lead II. Ventricular tachycardia persisting after six days of oral quinidine therapy (8 Gm. per day).

Lead II. Normal sinus rhythm after oral Pronestyl therapy.

Oral administration of Pronestyl is indicated in ventricular tachycardia and runs of ventricular extrasystoles. Intravenous administration is sometimes used in ventricular tachycardia and to correct ventricular arrhythmias during anesthesia. For detailed information on dosage and administration, write for literature or ask your Squibb Professional Service Representative.

PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

SQUIBB MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

COMMITTEE ON PUBLICITY

June 8, 1951.

Present: Homer G. Hamer, M.D., D. S. Megenhardt, M.D. and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of July 15, 1951—"Flies Spread Disease"

Week of July 22, 1951—"Accident First Aid"

Week of July 29, 1951—"Drug Addiction"

Week of Aug. 5, 1951—"Bank Your Blood"

The pamphlet entitled "Getting Well at Home" was approved for publication in the quantity of two hundred thousand, providing funds to defray the cost of publication were available. Request for funds is to be made from the A.M.A. Campaign Coordinating Committee.

The secretary read the quotation from the A.M.A. on larger quantities of the pamphlet entitled "Calling All Parents." The committee determined that no further action be taken on this matter.

The secretary read correspondence from the A.M.A. regarding the distribution and availability of recent *Reader's Digest* articles as a matter of information.

The secretary reported that WFBM again had time available for use of the committee and he was instructed to procure the latest series of transcriptions available from the Bureau of Health Education.

A Golden Opportunity
Awaits
The Right Doctor

in this small city of

MILLERSBURG, INDIANA
(Elkhart County)

Centrally located in a prosperous agricultural and industrial area.

New, luxurious home and office combined, designed specifically for a doctor, can be purchased or rented.

Within easy reach of excellent hospital facilities.

25,000 population within a 10-mile radius of Millersburg.

This small city has no general practitioner, and immediate community acceptance is assured.

Inquiries should be addressed to

ROY E. ROGERS
Box No. 5 Millersburg, Indiana

July 20, 1951

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; D. S. Megenhardt, M.D.; and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of August 12, 1951—"Planning That Vacation"

Week of August 19, 1951—"Time to Immunize"

Week of August 26, 1951—"Keep the Home Safe"

Week of Sept. 2, 1951—"Proteins Are Necessary"

The committee again discussed the purchase of sufficient copies of the A.M.A. pamphlet "Calling All Parents" for distribution of one copy to each physician, with a quotation of additional quantities if the physician desired to purchase additional quantities. The secretary was instructed to write Dr. W. W. Bauer, and seek a statement from him as to "just what is the purpose of the book and just what is supposed to be accomplished by the book?" The matter was then laid aside until the next meeting of the committee.

The secretary announced that the radio series entitled "Music With Your Meals" had been sent and was currently being used by radio station WFBM.

The questionnaire on the use of television and the television packets being distributed by the A.M.A. was discussed and the committee referred the matter to the Indianapolis and Monroe County Medical Societies, with the suggestion that they might like to give some consideration to this matter.

By consent the committee approved the report prepared for submission to the House of Delegates.



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*Cutting, W. C.: A Manual of Clinical Therapeutics, ed. 2, Philadelphia, W. B. Saunders & Co., 1948, p. 484.

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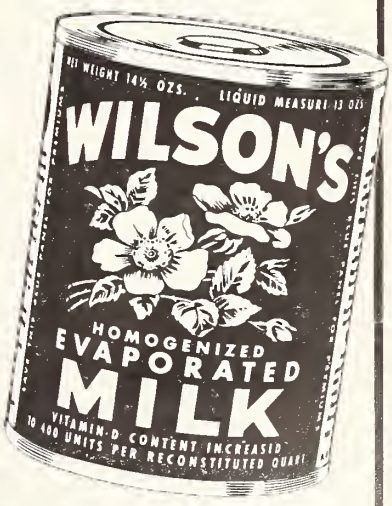
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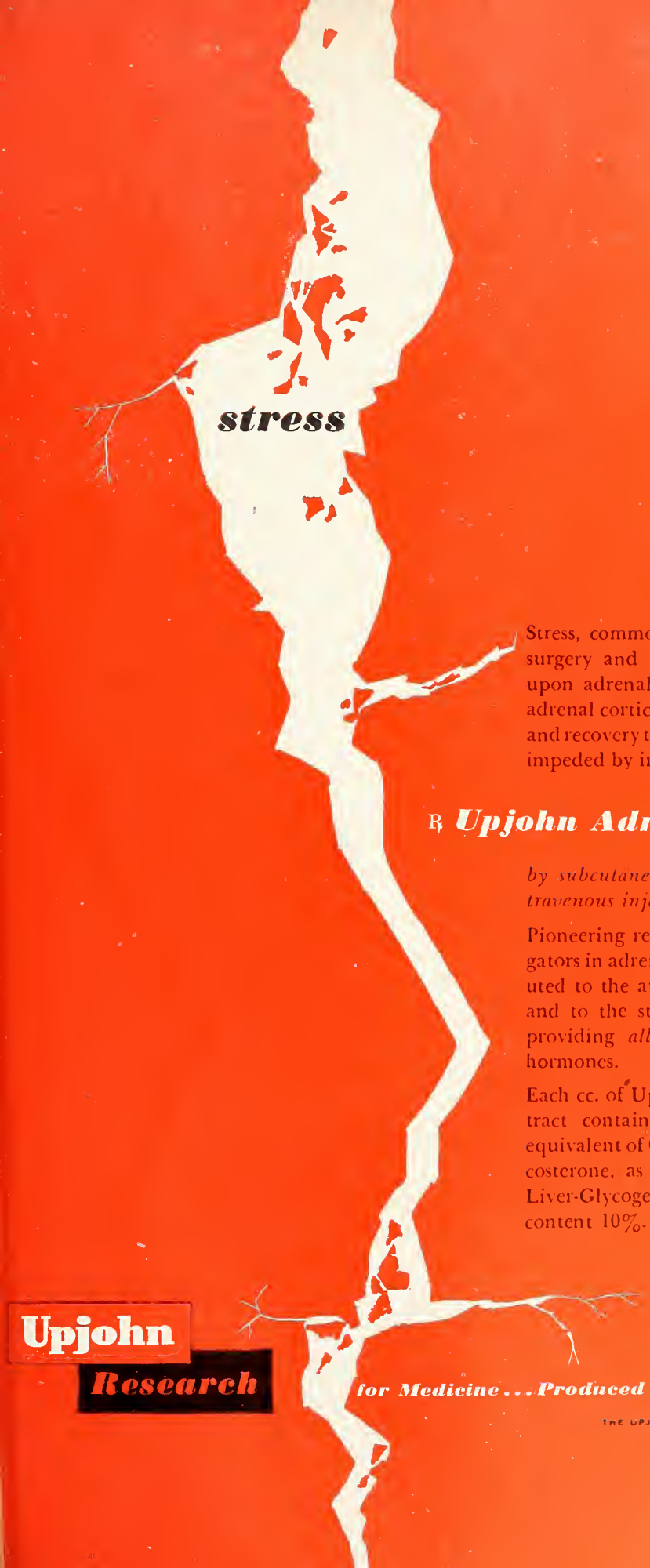
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PROVISIONAL ONE-STAGE OPERATION

In a Case of Gastrojejunocolic Fistula*

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INDIANAPOLIS

GASTROJEJUNOCOLIC FISTULA is an adventitious pathological short-circuiting connection between the stomach, jejunum and colon, resulting from perforation of a jejunal ulcer into the colon. Jejunal ulcer usually is the result of gastrojejunal anastomosis in cases where a high acidity and the ulcer diathesis persist, following gastric surgery. The close proximity of the colon in retrocolic anastomosis facilitates formation of a gastrojejunocolic fistula. Once this fistula is established, undigested food and acid stomach contents enter the colon, inducing an uncontrollable diarrhea as well as a state of dehydration, inanition and starvation. Fecal contents of the colon are in turn forced into the stomach, contaminating the upper digestive tract with feces which may be regurgitated or vomited. Thus the physiology of digestion and elimination is completely upset.

This case presents some unusual and interesting features from the point of view of etiology, diagnosis and plan of surgical management.

CASE REPORT

R. K., white male, age 45, weight 202 pounds, occupation tile layer, was in an automobile accident on November 11, 1948, being thrown against the steering wheel. He suffered contusions to his left arm, shoulder, chest and abdominal wall.

He was first seen on November 15, 1948, when he complained of weakness, nausea, vomiting of blood, tarry stools, abdominal pain and soreness. He was highly nervous, there was some tremor, his conjunctivae were pale and he had an anxious look. Pulse 120. Respiration 20. Temperature 99.6. Blood pressure 110S, 90D. On palpation there was much tenderness and rigidity in the epigastrium. He was sent to St. Francis Hospital where he was given blood transfusions and was placed on a high protein diet with amino acids and vitamins, with rapid improvement and cessation of hemorrhage from the gastrointestinal tract.

The past history revealed that he suffered from stomach trouble for many years. About 1938 he had a diagnosis of duodenal ulcer with massive hemorrhages resulting in surgical treatment. This consisted of a Finsterer exclusion and no-loop posterior gastrojejunostomy. Since this operation, he had no recurrence of massive hemorrhages. In 1940 there was x-ray evidence of jejunal ulcer at the stoma, showing varying degrees of activity at different times since; there was a tendency to heal and to recur periodically. On the whole, it was fairly manageable under medical treatment and diet. The patient was not anxious to have further surgery and seemed well reconciled that his condition was tolerable. He continued with his work almost uninterruptedly, up to the time of the accident.

On November 22, 1948, following the cessation of bleeding, an x-ray examination showed the existence of a jejunal ulcer with a crater. Medical treatment was continued to about February 15,

* Read before the Indianapolis Medical Society February 27, 1951.

Fig. 1



Evidence of jejunal ulcer Nov. 9, 1940, and after.

Fig. 2



X-ray Nov. 22, 1948, following injury to abdomen, showing jejunal ulcer.

1949, when the patient was markedly improved and considered himself well.

While convalescing in Florida, the patient noticed a diarrheal condition which was persistent. Upon his return in March, 1949, he was given a course of medical treatment including Sulfasuxidine, without much improvement. The patient lost 40 pounds in weight and was very weak. He had occasional vomiting of foul material. Chemical analysis after Ewald meal showed no free HCl. After histamine his free HCl. was 16 vol. percent, combined 32 vol. percent. At this point a diagnosis of gastrojejunocolic fistula was entertained. The x-ray showed a direct communication between the stomach, jejunum and colon. This was particularly true following a barium enema. The barium was seen to enter the stomach and small intestine immediately on injection. The jejunal ulcer appeared to be healed. The diagnosis of gastrojejunocolic fistula being certain, the patient was prepared for operation with a high protein diet, amino acids and vitamins. Sulfasuxidine, 12 grams daily, were given for three weeks. Penicillin and streptomycin were started two days preoperatively. The bowels were cleansed and blood transfusions given.

At operation September 27, 1949, under general anesthesia, a midline incision was made excising the old scar. The stomach and transverse colon were markedly adherent to the anterior peritoneum and protruded through a diastasis of the recti muscles. The adhesions were meticulously separated or dissected, being careful not to damage the blood vessels in the mesocolon, which was stretched thin, together with and behind the adherent omentum. The colon was then lifted and the area of the stoma was exposed. After freeing the jejunum, beginning at Treitz' ligament, it was found that there was a large fistulous tract which appeared to be an anastomosis between the gastrojejunal stoma and the transverse colon. The colon appeared smooth, distal to the fistula attachment, while it had normal striations proximally where it was functioning. The stoma was open, the fistula was well formed and about 2 cm. in thickness. The ulcer in the stoma appeared to be healed but was indurated. Deanastomosis was done, the old ulcer area was excised together with the edges of the stomach and jejunal openings. The fistula was excised together with the edges of the opening into the colon. This minimal resection was considered adequate for safe repair of the stomach, jejunum and colon, since the circulation was not greatly disturbed.

After deanastomosis and minimal resection, repair was done, the stomach opening was sutured lineally. The jejunal opening involving a half diameter of the gut and about 5 cm. distal from Treitz' ligament, was sutured transversely, insofar as mobilization permitted, but there was some narrowing of the lumen after placing two rows of sutures with additional reinforcing silk sutures. However, the lumen was adequate to carry the liquid duodenal contents. The transverse colon opening was sutured transversely for about half its diameter, with two rows of chromic sutures, reinforced with silk interrupted sutures. At this

Fig. 3



X-ray Nov. 12, 1949, one year following injury, showing gastrojejunocolic fistula.

Fig. 4



X-ray Jan. 18, 1951, about seventeen months following operation, showing complete restoration of colon without narrowing.

point the patient's pulse was 120, his blood pressure 80S, 40D, in spite of a continuous blood transfusion. It was considered imperative that the operation be brought to an early conclusion without resecting the stomach and inducing additional shock. Restoration of gastrointestinal continuity was done by a high anterior gastrojejunostomy, bringing up a short loop of jejunum anterior to the transverse colon, and anastomosing it to the upper anterior stomach wall, with a stoma 8 cm. wide. This makes it possible to resect more than half of the stomach at a second stage of the operation, without disturbing the new stoma, should it become necessary at some future time, if the ulcer diathesis persists. In this case the patient is doing excellently. He has regained his weight, does his normal work and has no digestive disturbances, eating regular meals without difficulty.

DISCUSSION

The difficulties of repair induced by the close proximity of the stoma and fistula to Treitz' ligament at the jejuno-duodenal junction were overcome by mobilization, minimal resection and transverse suturing. The no-loop retrocolic method of gastrojejunostomy is to be condemned as one breeding trouble, as shown in this case.

High anterior gastrojejunostomy was done without stomach resection. This has resulted in a satisfactory gastrointestinal function, persistently low acidity and satisfactory x-ray findings to date. Seventeen months after operation the x-ray showed good restoration of the transverse colon, stomach and jejunum. While there was radiologic evidence of some dilatation of the jejunal loop proximally and distally, it produced no symptoms to date. Adequate and prolonged preparation of the patient preoperatively improved his general condition, thus lessening the risk of a prolonged operation. It also reduced local inflammatory reaction and made possible the relatively simpler procedure of deanastomosis, minimal resection and repair with a high anterior gastrojejunostomy.

The chances of a permanent cure are generally considered least in the presence of a nonexcluded stomach, better with an excluded stomach, and the chances are, of course, best with a partial or subtotal gastrectomy. The latter is the best insurance against recurrence.

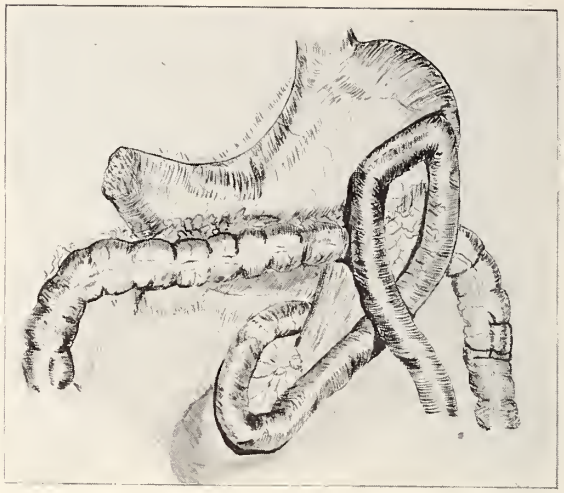
While this type of conservative minimal resection and repair, combined with a new anterior gastrojejunostomy, apparently gave a good result in this case, it may not be possible in all cases. The variety and complexity of operations employed by various surgeons bespeak the difficulties and the seriousness of the surgical treatment of this condition. To review only a few of the radical procedures used: Pfeiffer's two-stage operation involving colostomy and jejunostomy in the first stage, followed subsequently by deanastomosis, resection and repair of the colon, jejunum and partial gastrectomy with posterior gastroanastomosis, near the site of the old resected stoma, leaves much to be desired

Fig. 5



X-ray seventeen months after operation, showing some retention of barium in the stomach and some distention of both the afferent and efferent segments of the jejunal loop and the duodenum. This condition has so far produced no symptoms.

Fig. 6



Schematic appearance of the repaired and restored colon, jejunum and stomach with a high and wide anterior gastrojejunostomy.

physiologically. Lahey's operation in its first stage of ileosigmoidostomy, makes it imperative to resect most of the colon, together with most of the stomach and a good section of jejunum, involving also a difficult restoration of the continuity of the gastrointestinal tract and leaving behind a large pouch of nonfunctioning descending colon, often resulting in persistent diarrhea.

Nissen describes a method of treatment of gastrojejunocolic fistula. In the first stage the fistula is closed, the stomach divided, and anterior gastroenterostomy with enteroanastomosis is done. In the second stage, resection of the excluded portion of the stomach is done. In complicated cases he does extensive resection of the colon, closes the distal stump and brings out the proximal stump as an abdominal colostomy. In the third stage he interposes a segment of jejunum with attached mesentery between the closed ends of the transverse colon. The writer believes that in such cases of gastrojejunocolic fistula which are not obstructed and the amount of induration in the colon is not extreme, minimal resection and repair should be resorted to, and this followed by short loop anterior gastrojejunostomy without entero-anastomosis. If the patient's condition allows, partial gastrectomy may be done at the same time with antecolic Polya type anastomosis. Otherwise, stomach resection may be indefinitely postponed and the patient observed over a period of years, or resection may be done soon after the first stage, especially if the stomach free acidity is high, making recurrence of a marginal ulcer highly probable.

This type of operation, unlike that of Pfeiffer and Lahey, does not irretrievably commit the patient to multiple-stage extensive and radical operations, which carry a high mortality and morbidity. Such operations should be reserved for extremely complicated cases, where minimal resections and repair cannot be done. Wherever possible, reestablishment of function by reestablishing continuity of the gastrointestinal tract should be done as a first stage, such as here described, rather than dysfunctioning of a large part of the gastrointestinal tract, as is done in the Lahey short-circuiting operation, which must necessarily be followed by extensive resection of the dysfunctioned and short-circuited organs.

SUMMARY

A case of gastrojejunocolic fistula is presented, following abdominal injury twelve years after operation for bleeding duodenal ulcer, at which time gastric exclusion and retrocolic no-loop anastomosis was done. A provisional one-stage operation consisting of deanastomosis, minimal resection and repair of stomach, jejunum and colon, and a high anterior gastrojejunostomy was done. Stomach resection was deemed inadvisable at this time, owing to the poor condition of the patient. This can be done at any time in the future if advisable or necessary, without disturbing the newly applied gastrojejunostomy.

CIVILIAN GUNSHOT WOUNDS OF THE ABDOMEN

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INDIANAPOLIS

REVIEWS of large series of war wounds of the abdomen during the last six years have revealed a striking reduction in mortality rates. From an average mortality rate in World War I of approximately 60 percent the mortality rate in World War II dropped to as low as 20 percent in some reports. To determine if similar progress has been made in the management of civilian gunshot wounds of the abdomen an analysis has been made of 96 cases operated on at the Indianapolis General Hospital. These were consecutive, unselected cases admitted between January 1, 1940, and January 1, 1950, and included all patients who survived until surgery could be done. Eight of these patients were found at surgery to have no penetration of the peritoneal cavity, and were excluded from the series. In seven other cases the inflicting weapon was a shotgun. Because shotgun wounds of the abdomen are infrequent and present an entirely different problem they are not included. (Suffice it to say that only two of these cases survived, a mortality of 71 percent.) This leaves 81 cases in which surgery was performed because of penetrating, perforating bullet wounds of the abdomen inflicted by rifle or pistol.

In comparing war and civilian gunshot wounds of the abdomen certain similarities and differences should be kept in mind. While in war most of the patients are young and previously free of disease, these advantages are frequently discounted by reason of exposure, fatigue, malnutrition and delay in treatment. It is to be remembered, however, that many critically wounded battle casualties do not survive long enough to reach surgery and thus are not included in operative statistics. Though alcoholism, older age and occasional pre-existing diseases can complicate the civilian victim, he is usually within quick access to shelter and hospital care. War wounds are caused by a variety of highly traumatizing missiles, such as bomb and mortar fragments and high velocity bullets. In civilian life the weapon is usually a less traumatizing pistol or rifle. In spite of these facts civilian gunshot wounds of the abdomen have continued to carry a higher mortality rate as proved by the figures of different authors in Table I. Exceptions are the reports by Zinninger,[1] Sloan,[2] Welch and Giddings,[3] and Poer.[4]

In Indianapolis, as in any other city, a majority of gunshot wounds of the abdomen seem to occur in people eligible for municipal hospital care. This is borne out by the figures in Table II which represent the number of cases operated upon at the other hospitals in the city during this period. The facilities for handling such an emergency at this institution appear optimal. They include: 1). A rapid and efficient ambulance service, 2). An efficient working relationship with the Indianapolis Police Department, 3). Adequate receiving ward equipment, and personnel familiar with shock and its treatment, 4). 24-hour x-ray service, 5). Operating room facilities, and 6). Anesthesia. An additional aid to the preoperative management has been the recent use of Witebsky's Blood Group Specific Substances A and B solution for making large volumes of Type O whole blood available in a short time. The "shock cart," an exceedingly useful device, equipped with a Bucky plate for x-rays, standards to support transfusion bottles and adjustable elevating shaft to raise the foot of the cart bed into "shock" position, has greatly facilitated handling of the patient on admission.

On arrival of the patient in the receiving ward, intravenous fluids are begun immediately. Blood

TABLE I

MORTALITY RATES OF GUNSHOT WOUNDS OF THE ABDOMEN

REPORTED BY OTHER AUTHORS

Civilian Series

Author		No. Cases	Mortality %
Rippy	1941	337	60.5
Hamilton and Duncan	1943	182	48.9
Elkin and Ward	1943	181	46.4
Sloan	1944	35	14.3
Zinninger	1944	46	11
Wilkinson, et al	1946	104	60
Taylor	1946	69	36.2
Poer	1947	62	17.7
Welch and Giddings	1950	28	7.7

War Series

Ogilvie	1944	373	43.4
Imes	1945	349	29
Bradford, Battle & Pasachoff	1946	312	20.2
Jarvis, Byers & Platt	1946	128	28.7
2nd Aux. Surg. Group	1946	3503	25.5

TABLE II

GUNSHOT WOUNDS OF ABDOMEN OPERATED UPON AT OTHER HOSPITALS IN INDIANAPOLIS

St. Vincent's Hospital	(1940-1950)	12 cases
Long Hospital	(1940-1950)	5 cases
Methodist Hospital	(1943-1950)	14 cases
TOTAL		31 cases

* Department of Surgery, Indianapolis General Hospital.

is typed and cross-matched for transfusion regardless of the presence or absence of shock. Of the cases studied, 36 or 44 percent suffered some degree of shock between admission and surgery. Taylor[5] has indicated the improvement in mortality rate at this hospital between 1938 and 1946 resulting from the more liberal use of plasma and whole blood before, during, and after surgery. Morphine is used when necessary to relieve pain but is not given as a matter of routine to every patient. We have been impressed by the frequent absence of pain initially, followed by the gradual development of pain, tenderness, and rigidity after a period of time. It is felt that these are valuable indications of the extent of injury, not to be masked by narcosis. Abdominal tenderness and rigidity were present in some degree in 69 patients (85 percent). Vomiting was infrequent, occurring in only 14 cases, or 17 percent. When present, vomitus should be examined for fresh blood as an indication of gastric perforation. It was present in four cases, all of which were found to have gastric perforations. Levin suction was used frequently, even in the absence of vomiting and particularly when food or liquid had been ingested recently. Roentgen examination of the abdomen was usually used only when a wound of exit could not be found or the presence of a slug within the body could not be ruled out. In situations in which the bullet has not left the body it is considered of utmost importance to locate it by x-ray so that its route through the body may be mentally reconstructed. It is our opinion that bullets usually traverse a relatively direct course through the abdomen unless, of course, they are deflected by ribs or spine. Oberhelman and LeCount[6] state that side to side injuries in the abdomen are most serious, bullets entering from front to back the next most serious, and those entering from the back are usually the least serious.

The white blood cell count was found to be elevated in 81 percent of the cases in which it was done. The average white blood cell count was 16,000. Urinalysis is imperative and in nine cases in which blood was present in the urine, injury to the kidney, ureter or bladder was found.

OPERATIVE MANAGEMENT

That surgery should not be undertaken until the patient's condition permits, (i.e., on recovery from shock), is a valuable dictum. However, when the blood pressure does not respond to adequate antishock measures it is considered imperative to proceed with exploration because of the possibility of persistent intra-abdominal bleeding and/or overwhelming peritoneal contamination. Welch and Giddings[3] state that, "prolonging of the time interval from injury to surgery increases the gravity of the prognosis." Imes,[7] in a review of war wounds of the abdomen, does not agree with this and states that the factor of time-lag between injury and surgery appears relatively unimportant. In our series the average time between admission to the hospital and surgery was 2.7 hours.

Resident surgeons operated upon 50 cases, or 61.73 percent. The remainder were operated upon by attending staff surgeons. The anesthesia of choice was nitrous oxide-oxygen-ether, being used in 50 cases, or 68 percent. The next most frequently used anesthetic was open drop ether, being used in 22 cases, or 27 percent. In recent years endotracheal intubation has been used almost routinely, as well as curare. Doud and Shortz[8] believe that the use of curare has been of great aid, particularly for prolonged procedures in shocked patients when a light plane of anesthesia is desirable.

The abdominal incision most frequently used was the rectus muscle splitting or retracting type. This was used in 64 percent of the cases.

Wilkinson et al[9] have pointed out that the frequency with which organs are injured in gunshot wounds of the abdomen is in direct proportion to the volume they displace in the abdominal cavity. Such was the finding in this series, small intestine, liver, colon and stomach being involved in that order of frequency. Perforations of small intestine were routinely repaired by either a transverse row of interrupted sutures or by purse-string sutures. In repairing segments of irreparably damaged small bowel primary resection and anastomosis was carried out in 14 cases. Five of these cases died. In two cases two separate resections and anastomoses were done, with recovery of both patients. While some surgeons advise against primary bowel resection in extensive abdominal wounds, we believe such a procedure does not appreciably increase the risk. Imes[10] is in accord with this view and claims, ". . . the hazard of such a procedure appears less real than heretofore believed, when the extent of visceral injury is considered. Exteriorization of the small bowel should not be done."

Management of liver wounds varied with the operator. In general, however, it was found that perforations were not bleeding at the time of surgery and thus were usually neither packed nor sutured. Extensive wounds or bleeding wounds of the liver were either sutured with mattress sutures of catgut or packed with absorbable cellulose compounds or muscle. A majority of them were drained. No relationship could be found between mortality and the type of management of wounds of the liver.

Though civilian gunshot wounds of the abdomen involve the colon with approximately the same frequency as war wounds, the severity of injury is usually much less. To this can probably be attributed the infrequent necessity of exteriorization or decompressive colostomy in the former type. Though perforations of the colon were encountered in 28 cases (35 percent), colostomy was performed in only three cases and decompressive appendicostomy in two cases. In all other cases perforations

were repaired by either interrupted sutures or pursestring sutures. That colostomy may have been indicated more frequently in this series is seen in the fact that in ten of the twenty-two deaths, injury to the colon had been sustained and in none of the ten was colostomy performed. Pilcher,[11] in an extensive review of war wounds of the colon, rectosigmoid and rectum, concluded that "while in general, some form of exteriorization colostomy is the method of choice in treatment of wounds of the colon, small single perforations of the colon may, on occasion, be closed by simple suture. For most wounds, however, tangential exteriorization or loop colostomy is the treatment of choice." He further advised that wounds of the intra- and extraperitoneal rectosigmoid and rectum be treated by simple suture and proximal decompressive colostomy.

Injury to the spleen occurred in six cases. Conservative management was used in one, with survival, and splenectomy in the remaining five, with two deaths. Perforation of the gallbladder occurred in five cases, four being repaired by simple suture and the other being treated by cholecystostomy. Of these five cases, one died, after simple suture. (This patient also sustained wounds of the liver and right kidney.) Wounds of the kidney occurred in 11 cases, with nephrectomy being performed in two cases. Both of the latter survived.

The relationship of extent of visceral injury to mortality rate is shown in Table III. This is in agreement with the findings of others, namely, that the mortality rate from abdominal wounds is in direct proportion to the extent of visceral injury. This is further supported by the fact that the mortality rate in 35 cases of single viscus involvement was 17 percent, whereas the mortality rate in 46 cases of multiple viscus injuries was 34.7 percent.

The abdomen was drained in 40 cases, or 50 percent. Sulfonamides were placed in the peritoneal cavity in only 17 cases, or 20 percent. No obvious effect on mortality rate could be noted by the use or omission of these two procedures.

RESULTS

Eighty-nine cases of bullet wounds of the abdomen were operated upon. Eight of these patients were found to have no penetration of the peritoneal cavity. No deaths occurred in this group. Of the remaining 81 cases of penetrating wounds of the abdomen there were 22 deaths, a mortality rate of 27.15 percent. Nine, or 40 percent, of the deaths occurred within the first 48 hours following surgery. Two of these patients succumbed while still on the operating table. Five deaths occurred between two and six days following surgery. The remaining 8 deaths occurred between nine and sixty days postoperatively, with an average of 26.8 days.

A complete record of the causes of death in this series, unfortunately, is lacking. As nearly as can be determined from a review of the charts, hemorrhage and/or overwhelming peritoneal contamination accounted for all deaths which occurred within 48 hours of surgery. Of the five cases in the next group, peritonitis was found at autopsy in two and pulmonary edema (excessive intravenous fluids) in one. The other two were not autopsied. In those patients dying after the sixth day, five were believed to have had generalized peritonitis or intraperitoneal abscesses. One died of meningitis secondary to a gunshot wound of the spinal cord and another died from massive hemothorax and atelectasis associated with a thoraco-abdominal wound.

The commonest postoperative complication was wound infection, occurring in 25 percent of the cases. This appears to be an inordinately high figure but is in keeping with the findings of others. Imes[10] states that, "therapy appears to have favorably influenced the factor of infection in the mortality rate but localized infections appear to occur with undiminished frequency." It is of interest to note that 80 percent of the cases in this series received postoperative chemotherapy and antibi-

TABLE III

RELATIONSHIP OF EXTENT OF VISCERAL INJURY TO MORTALITY

VISCUS	ONE VISCUS INJURED			TWO OR MORE INJURED		
	Cases	Deaths	Mortality	Cases	Deaths	Mortality
Small Intestine	13	1	7.6%	23	8	34%
Liver	10	2	20 %	22	10	45%
Colon	8	2	25 %	20	7	35%
Stomach	2	1*	50 %	14	4	28%
Kidney	0	0		11	5	45%
Spleen	2	0		4	2	50%
Gall Bladder	0	0		5	1	20%
Rectum	0	0		2	0	
Urinary Bladder				4	1	25%

(*Death due to G.S.W. spine complicated by meningitis).

Mortality for single viscus injury: 35 cases 6 deaths 17 %

Mortality for multiple viscus injury: 46 cases 16 deaths 34.7%

otics. It was used in all but eight of the cases which died, and five of those eight died within the first 24 hours. We conclude, therefore, that although antibiotics and chemotherapy have increased the victim's chances for survival, the factors of severity and extent of visceral involvement, degree of peritoneal insult and gravity of hemorrhage still play the most important roles determining mortality rate.

SUMMARY

1. A statistical analysis of 96 cases of gunshot wound of the abdomen has been presented, 81 of which sustained penetrating, perforating bullet wounds of the abdomen treated by surgery.
2. Comparison of statistics for war and civilian gunshot wounds of the abdomen reveals a greater reduction in mortality rate for a larger group of war wounds than has been reported for civilian wounds.
3. The frequency with which abdominal viscera are injured in gunshot wounds of the abdomen is in direct proportion to the volume which they displace in the abdominal cavity.
4. The mortality rate from abdominal wounds is in direct proportion to the extent of visceral damage, (mortality rate in 35 cases of single viscus involvement was 17 percent whereas mortality rate in 46 cases of multiple viscus injuries was 34.7 percent).
5. The mortality rate for 81 cases of penetrating, perforating bullet wounds of the abdomen was 27.15 percent.
6. Hemorrhage and peritonitis continue to be the leading causes of death in bullet wounds of the abdomen.
7. Postoperative wound infection continues to occur with undiminishing frequency.
8. Although antibiotics and chemotherapy have undoubtedly helped to reduce the mortality rate from gunshot wound of the abdomen, survival of the patient still depends largely on the severity and extent of visceral injury, degree of peritoneal insult and gravity of hemorrhage.

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CYSTICERCUS CELLULOSAE IN MAN

A Case Report

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CYSTICERCUS CELLULOSAE has often been reported in man. By far the greater number of cases have been reported in the foreign literature. L. A. Fortier[1] reports a case and comments on the report of E. J. H. Roth,[2] in which the frequency of occurrence in the United States is alleged to be high. This is not substantiated in the American literature. The occurrence of this disease in man seems rather frequent in China, six cases having been reported at the Peiping Medical Union College.[3]

Man is ordinarily the host of the adult form of Taenia solium, the band worm, a not uncommon occurrence. The natural intermediate host is the pig. The adult worm discharges the free ova or the proglottides from the host, usually man, via the feces. These are ingested by the pig and the oncospheres or embryos are liberated. These bore through the intestinal walls and are carried by the blood channels or the lymphatics to the pig's musculature. In the latter site they mature into the bladder worms or cysticerci proper. Pork which contains the small white bladder worms is known as "Measly pork." Man, eating the pork, will digest the bladder worm. The scolex of the latter will turn itself inside out and by means of its "hooks" will anchor itself on the intestinal wall. In two or three months this will develop into the adult worm capable of excreting proglottides or ova. The latter are probably extruded by their own activity from the proglottid or by its rupture. The ova extruded from the feces of man normally complete a cycle.

It becomes possible for man to act as the intermediate host if the ova or proglottides are regurgitated into the stomach after being freed in the small intestine, an internal self-contamination. Man may also by ingestion of feces of a man, not a final host, act solely as an intermediate host.

The diagnosis is commonly made by roentgenographic soft tissue study. It is often an incidental finding. Smithers[4] states that at least five years must elapse before the appearance of the calcified encysted forms in the muscles or the central nervous system. As seen on roentgenograms the calcifications are usually ovoid, oval with dot, or fusiform. They measure 2 to 9 mm. in length and 0.5 to 2 mm. in width.[5] The longitudinal axis of calcification will follow the axis of the muscle bundles

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Fig. 1



and they will usually be concentrated over the pelvis and thighs. They are generalized, however. The calcifications may very easily be overlooked, particularly if they are sparse in distribution.

The serious and clinically important findings are calcifications in the brain substance, an uncommon cause of epilepsy. Of the seventy-nine cases reported by Smithers,[4] seven were found with calcifications in the brain. Denny-Brown[6] reports the only case of calcifications in the brain that were not accompanied by general musculature calcifications. The cause of epilepsy is felt to be on the basis of reaction to a foreign body. When the oncospheres reach the brain there develops a sclerosing wall of neuroglia with few round cells and plasma cells between this area and the normal brain tisue. When the cysticercus dies there is degeneration of the surrounding tissue as well, resulting in brain necrosis with a new wall of neuroglia.[7]

CASE REPORT

A 45 year old, colored man, was admitted to the surgical service of the Indianapolis General Hospital with severe abdominal pain. The previous history and admission symptomatology was that of gallbladder disease. After the acute phase of the disease had subsided a cholecystectomy was performed and recovery was uneventful. Chronic cholecystitis was the diagnosis made in the pathologic report upon the removed gallbladder.

During the preoperative procedures a survey film of the abdomen was obtained and numerous ovoid soft tissue densities were noted within the pelvic musculature. These were calcific in quality and ovoid in shape, average size being 2 by 8 mm., and

they presented their long axes in the direction of the muscle bundles. They were felt to represent in all probability calcifications due to the presence of the bladder worm, cysticercus cellulosae. They were distributed over the pelvis (Fig. 1) and thighs and to a lesser extent in the arms, shoulders, lower portions of the lower extremity, and the thoracic and abdominal musculature. Examination of the skull was negative.

Review of the past history elicited no symptomatology that could be attributed to the condition and source of contamination could not be ascertained. Biopsy of the lateral thigh flexors was performed and a small 1.2 by 0.7 by 0.3 cm. calcification, ovoid in shape and whitish yellow in appearance, was removed. The pathologic report was "calcified cyst." From the roentgenographic appearance, the gross characteristics of the removed specimen and the pathological description, it is felt that this represents a true case of bladder worm, cysticercus, infestation in man.

DISCUSSION

A case of cysticercus cellulosae is reported in a 45 year old, colored man, a life-long resident of Indiana. This is believed by the authors to be the first case reported in the northern portion of the United States. More cases may be expected in service personnel, whose tour of duty was in areas where apparently the condition is more common.

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TELEPHONE SERVICE

Special telephone service has been provided for the convenience of physicians attending the convention. Incoming calls will be received in the "Telephone Room," off the Murat theater lobby. The number is PL. 2408. Doctors expecting calls should leave word in the "Telephone Room" where they may be located.

Doctors will make outgoing calls on pay telephones in the theater lobby, and at the top of the stairs leading to the Dining Room. Three extra telephone booths have been installed, making a total of five available.

In order that the lines may be kept clear for incoming calls, no outgoing calls will be permitted from the "Telephone Room."

Doctors attending the dinner at the Indiana Ballroom Wednesday night may be reached by calling LI. 0553 or LI. 0921.

PULMONARY CALCIFICATION AND HISTOPLASMIN SENSITIVITY IN NORTHERN INDIANA

JOHN A. SHIVELY, M.D. AND WALLACE S. TIRMAN, M.D.*

BLUFFTON

PULMONARY CALCIFICATION in an individual with neither a clinical history of tuberculosis nor a positive tuberculin skin test has been the object of considerable controversy and investigation during the past decade. Long and Stearns[1] found a geographical distribution of pulmonary calcification with the highest incidence in men from the east central portion of the country in a study of chest films of Army inductees. Christie and Peterson[2] in a study of histoplasmin and tuberculin sensitivity together with chest x-rays of children from Tennessee, concluded that there was a relationship between histoplasmin sensitivity and pulmonary calcification. At approximately the same time Palmer[3] in a nation-wide survey of student nurses, found that those states in which the frequency of reactions to histoplasmin was high were also those states with the highest incidence of pulmonary calcification. These studies have been followed by numerous surveys[4,5,6,7] of school children, nurses and college students which have shown a correlation between the pulmonary calcification and the histoplasmin sensitivity with the greatest prevalence of both of these in the central and lower Mississippi River Basin. Furthermore, the development of calcified miliary pulmonary lesions in a patient from whom Histoplasma capsulatum was isolated and who also was sensitive to histoplasmin would indicate more than just a statistical correlation between pulmonary calcification and histoplasmosis.[8] These observations have prompted a recent reviewer[9] of the problem to state that in New York City one would be about 90 percent correct in attributing pulmonary calcification in a native to a tuberculosis infection, while in Cincinnati the chances would be 3 to 1 that such a conclusion would be wrong.

Several of these studies have included residents of Indiana, but no definite incidence of pulmonary calcification or fungus sensitivity in persons from this state has been reported. Consequently, a limited number of persons with x-rays of the chest were skin tested with several different antigens in an attempt at evaluation of this problem.

MATERIALS AND METHODS

A total of 103 adult persons consisting of ambulatory patients and hospital personnel were given intradermal skin tests consisting of 0.1 cc. of a 1/1000 dilution of histoplasmin,** 0.1 cc. of a 1/1000 dilution of blastomycin,** 0.1 cc. of a 1/1000 dilution of coccidioidin,† and 0.1 cc. of a buffered saline solution containing 0.00002 mgm. of tuberculin purified protein derivative (P.P.D.)—first strength tuberculin. The syringes and needles were used only for the same antigen in order to eliminate possible false reactions. Most of the individuals tested were from north and central Indiana with a smaller portion from northeast Ohio, and each one was questioned as to site of previous residence. The age of the persons ranged from 18 to 82 years, (the majority ranged from 20 to 65 years) and none was either acutely ill or had clinical or roentgenological signs of active tuberculosis. These tests were read at 48 hours and were considered positive if there was an area of induration which measured 5 or more millimeters in diameter. A limited number of those persons who reacted to the histoplasmin, but failed to do so with the tuberculin and who were available for the subsequent 48 hours, were retested with a P.P.D. test dose of 0.005 mgm.—second strength tuberculin.

Teleoroentgenograms of the chest in the posteroanterior position were made in 99 of the 103 persons and these were read without knowledge of the results of the skin tests.

RESULTS

Eighty (77.6 percent) of the 103 persons skin tested reacted to histoplasmin, with 33 (32.0 percent) reacting to the tuberculin test. Fifty-four (51.4 percent) persons reacted to histoplasmin but failed to react to tuberculin.

Only 2 patients reacted to coccidioidin (both reacting to histoplasmin but not to the tuberculin test) and both had been in the endemic areas of coccidioidomycosis in the southwestern United States. A total of 31 (30 percent) persons reacted to the blastomycin with all of these reactions occurring in patients with a positive histoplasmin test, and usually the reaction to blastomycin was the smaller.

The results of the skin tests and their correlation with the presence or absence of pulmonary calcification are shown in Table I. Of the 99 patients

* From the Department of Medicine and Radiology, Caylor-Nickel Clinic & Clinic Hospital, Bluffton.

** Obtained through the courtesy of Dr. Arden Howell, Jr., U.S.P.H.S. Medical Mycology Laboratory, Duke University School of Medicine, Durham, North Carolina.

†Obtained through the courtesy of Dr. Charles E. Smith, School of Public Health, University of California, Berkeley 4, California.

TABLE I

Chest x-ray	No. of persons	Hist.- Tub.+	Hist.+ Tub.-	Hist.+ Tub.+	Hist.- Tub.-	Total Tuberculin Positive	Total Histoplasmin Positive
With calcification	43	1(2.3%)	26(60.5%)	12(27.9%)	4(9.3%)	13(30.3%)	38(88.6%)
Without calcification	56	5(9.0%)	26(46.4%)	10(17.9%)	15(26.6%)	15(26.6%)	36(64.3%)

receiving chest x-rays, 43 (43.4 percent) had some form of pulmonary calcification. In the group with calcification, 13 (30.3 percent) had a positive tuberculin test and 38 (88.6 percent) had a positive histoplasmin test. In this group only 1 person had a positive tuberculin test with a negative histoplasmin skin test. Opposed to this, there were 26 (60.5 percent) who had positive histoplasmin negative tuberculin tests. Seventeen (39.7 percent) had both positive histoplasmin and tuberculin tests, whereas 4 (9.3 percent) had both tests negative.

Consideration and comparison of the 56 patients without calcification is also seen in Table I. It is noted that 15 (26.6 percent) of the patients had a positive tuberculin test and 36 (64.3 percent) had a positive histoplasmin test. Five patients (9.0 percent) had a positive tuberculin and negative histoplasmin test, whereas 26 (46.4 percent) had a positive histoplasmin but negative tuberculin test. Ten (17.9 percent) had a positive histoplasmin and a positive tuberculin test, whereas 15 (26.6 percent) had a negative histoplasmin and tuberculin skin test.

A critical evaluation of the types of pulmonary calcification found failed to reveal any pattern as seen on the chest x-ray which would absolutely be assumed to be due to histoplasmosis. However, the presence of disseminated, multiple bilateral calcifications in a patient with a positive histoplasmin reaction may well be due to histoplasmosis, as pointed out by others.[4,8,9,10] All of the chest films were inspected for splenic calcification but none was found. Because of the limited number of patients subjected to the second concentration of P.P.D., no conclusion could be drawn from the results obtained, although several patients with a negative first strength P.P.D. test had a positive reaction with the second strength test. An attempt was made to correlate the results obtained to the different age groups tested, but no correlation was found other than an increase in the number of tuberculin reactions in the middle age groups (40-60 years).

DISCUSSION

The high incidence of histoplasmin sensitivity (77.6 percent) is significant and would tend to confirm the impression that an infection with Histoplasma capsulatum is usually benign and with only an infrequent case progressing to a systemic and usually fatal disease.

Of the 43 patients with pulmonary calcification, 38 (88.6 percent) reacted to this antigen while only 13 (30.3 percent) reacted to the first strength dose of tuberculin (P.P.D.). This would suggest that histoplasmosis might be the etiological agent of the calcification. A possible objection would be the low dosage of tuberculin used (0.00002 mg.). The concentration of 0.0001 mgm. of P.P.D. used in the U. S. Public Health survey is based on the quantitative studies of the tuberculin reaction by Furcolow, et al.[11] However, examination of his results reveal only a small difference in the number of reactions between these two dosages. Furthermore, their observation that almost all persons tested will react if sufficiently large doses of tuberculin are given is further substantiated by the observation by Palmer, et al.[12] The geographic distribution of reactions in persons being retested with 0.005 mgm. dose were strikingly independent of the first dose reactions. Also the proportion of the second dose reactions was higher in rural than in urban areas in contrast to the proportion of first dose reactions. He raises the possibility of nonspecific sensitivity to the larger doses of tuberculin by infection by an organism antigenically related to the tubercle bacillus.

Of the 56 patients who had no pulmonary calcification, 36 (64.3 percent) had a positive histoplasmin test with 15 (26.6 percent) reactors to the tuberculin test. The total number of positive tuberculin tests in patients without calcification corresponds rather closely to that in patients with calcification and the percentage showing a positive histoplasmin test is high in patients with or without calcification.

Correlation of the results of the skin tests with the presence of calcification reveals a rather high incidence of positive histoplasmin tests and a relatively low incidence of positive tuberculin tests in patients with or without calcification. Even though the incidence of positive skin reactors to histoplasmin is higher in those patients with pulmonary calcification, one is impressed with the same basic pattern of reactions to these skin test antigens in each group. This raises the question as to whether histoplasmosis is the principal etiological agent of the pulmonary calcification. However, these results agree with previous observations that there is a high incidence of positive skin reactors to histoplasmin in patients with pulmonary calcification.

That there is some connection between tuberculosis and histoplasmosis in the occurrence of pul-

monary calcification is shown by the incidence of negative skin reaction to both tuberculin and histoplasmin. In the group with calcification this was 9.3 percent, whereas in the group without calcification it was 26.7 percent.

The low incidence of reactions to coccidioidin in this area would tend to eliminate coccidioidomycosis as a cause for pulmonary calcification. The association of the positive reactions to blastomycin with a larger positive histoplasmin reaction indicates a cross sensitivity between these two antigens, as has been shown previously,[13,14] with the true sensitivity being to histoplasmin, in all probability.

SUMMARY AND CONCLUSIONS

Of a total of 103 persons who were skin tested with tuberculin, histoplasmin, blastomycin and coccidioidin, 77.6 percent reacted to histoplasmin, 32 percent to first strength tuberculin and only 2 percent to coccidioidin. Thirty-one percent reacted to blastomycin but these were always associated with a positive and usually larger reaction to histoplasmin and probably represents a cross-sensitivity to the latter. Forty-three of 99 patients from this group had some form of pulmonary calcification, with 88.6 percent of those with calcification having a positive histoplasmin reaction, while only 30.3 percent had a positive first strength tuberculin test. In the group without pulmonary calcification, 64.3 percent had a positive histoplasmin reaction, whereas 26.6 percent had a positive tuberculin reaction.

The high incidence of histoplasmin sensitivity would indicate the widespread presence of benign infections due to Histoplasma capsulatum in this area. However, the high incidence of reactors to this antigen in patients without pulmonary calcification limits the incrimination of this agent in the production of pulmonary calcification.

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The schedule of courses and the order blank for tickets for the Instructional Courses are on page 975 of this issue.

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EMPLOY THE HANDICAPPED

NATIONAL Employ the Physically Handicapped Week will be observed from October 7 to 13.

President Truman has pointed out that this week should be utilized to call special attention to the need for increased employment of the handicapped, and that the remaining weeks of the year should be devoted to obtaining the widest possible public understanding of the problem.

Experience in industry has proven that handicapped persons usually make the best workers. They turn in better attendance records, and suffer fewer injuries than do their more fortunate colleagues. When properly trained for a specific job they are excellent producers.

As the defense program is gaining momentum, manpower shortages are developing. It is imperative that every skill which the nation possesses, and every skill which it can develop be put to a useful purpose.

The President's committee, under the chairmanship of Admiral Ross T. McIntire, has the cooperation of business, labor, and all public-spirited organizations, in developing a program for the rehabilitation and training of the physically handicapped. In the six years since the state employment services were inaugurated, more than 1,300,000 handicapped workers have been placed in jobs which they can handle.

The medical profession takes a deep interest in this program, since it is not only developing a great national asset, but is also contributing to the well-being and happiness of each handicapped person who is successfully employed.

DIABETES DETECTION

THERE are approximately one million known diabetics in the United States. It is estimated that there are an equal number of unknown diabetics. There are also probably about two million potential diabetics who will develop the disease at some indeterminate date in the future.

Diabetes mellitus is a disease which does well under careful management. This is especially true if the condition is diagnosed and treated in its early stages. The course of a diabetic will be smoother if control is established soon after inception of the malady.

Everything about the disease emphasizes the advantages of early and careful treatment.

Because of these advantages and because of the large number of new diabetics discovered each year, it is the goal of the American Diabetes Association to have every person tested for glycosuria at least once a year.

The association sponsors a year-round detection program. This is spearheaded by Diabetes Week, which this year will be November 11 to 17. The Indiana State Medical Association, through its Committee on Diabetes, and many of the county medical societies are planning to participate.

During each of the three past years the diabetes detection drive has uncovered a fairly constant number of previously undiagnosed diabetics—0.5 to 1 percent of all persons tested. In 1950 some communities reported as high as 2.5 percent. This increased yield is apparently due to broader coverage and more widespread testing.

The effect of this activity is not only to promote early diagnosis, but also to aid in dissemination of information about diabetes. Due to the manifest advantages of modern treatment, everyone and especially the relatives of known diabetics should be encouraged to participate in regular diagnostic tests.

AAPS ANNUAL MEETING

THE Association of American Physicians and Surgeons will conduct its annual national meeting in Indianapolis on October 4, 5 and 6, 1951. All members of the Indiana State Medical Association have been invited to attend the sessions. No registration fee is to be charged.

Dr. Lawerence Shinabery of Ft. Wayne is the national president of the organization this year. He and his committees have arranged an outstanding program, the theme of which will be "Freedom." Several national freedom groups will present exhibits.

The speaking program will discuss medical economics, medical legislation and freedom. Many well known speakers will participate, including the Honorable J. Bracken Lee, Governor of Utah, Mr. George N. Craig, past National Commander of the American Legion, and Dr. Clarence E. Umphrey, President of the Michigan State Medical Society.

TECHNICAL EXHIBIT

PLANS for the 102nd Annual Convention include a Technical Exhibit which promises to be the best ever to be presented to the association. It will rival in size any of its predecessors, and has already outgrown the space which was originally allotted to it.

Ninety-six exhibit spaces have been sold to 91 exhibitors. Advance notices indicate that a wide variety of products of interest to physicians, including many of the newer pharmaceuticals, will be on display. Well instructed detail men will be on hand to dispense information and answer questions.

The scientific program has been arranged to provide for several open intervals during each day for the viewing of exhibits. It is hoped that those who attend the convention will take advantage of these opportunities. Much valuable information may be obtained. It is also a practical way in which to reciprocate for the interest and financial support which the exhibitors contribute to the meeting.

Editorial Notes

Early results have been favorable in the clinical testing of a new antimalarial drug by the U. S. Army. If subsequent experience confirms the findings of the original investigation the drug will probably be more effective for the treatment of malaria than any drug now in use. The new preparation is called primaquine. It appears to be especially effective against the tissue phase of the disease. Chloroquine is the suppressant drug now in use by the armed forces. It is effective against parasites in the blood stream. Combination of the two may be useful in effecting rapid cures of malaria when troops are moved out of malarious regions. Relapses which are common under present treatment would thus be prevented.

Although there are more than 800 reported cases of malaria in the country, only three cases have been reported in Indiana. These cases were contracted in Korea by returning military personnel. One was in Vigo county, one in St. Joseph county, and one in LaGrange county.

Health officials point out that since the disease did not become established after World War II, when many troops had been in tropical areas, there is little likelihood that military personnel returning from Korea will cause an epidemic at this time.

If all cases of malaria are reported as they appear, health departments can then take necessary steps to stamp out the disease.

The American Cancer Society has announced the publication of a "Manual of Tumor Nomenclature and Coding." Work on the volume has extended over the past three years. It is the first major attempt to clarify and standardize the terminology of cancer and will be distributed widely. It deals with both benign and malignant tumors and is a long step forward in providing a common language for a most complex subject. It is designed to be used in conjunction with "Standard Nomenclature of Diseases" and "International Statistical Classification of Diseases, Injuries and Causes of Death."

The Owen-Monroe County Medical Society has announced the completion of a four-point summer program. Their second annual "Essay Contest" has been successfully completed. In May the society passed a resolution to endorse the stand the Farm Bureau is taking against all controls; copies of the resolution have been sent to all Indiana Farm Bureaus. In August the society and its auxiliary sponsored a hospitality booth at the Monroe County Fair, and conducted a ceremony, as a part of the Fair program on August 24, to present a "Freedom Library" to each of the 14 high school and public libraries in the two counties.

President's Page

LOOKING BACK

AS THE END of my term of office draws near and it is realized that this is the last time I will speak through this page, I confess to some mixed feelings. At the beginning of the year, as is true when we start anew at any project, we had great plans to accomplish many things for the good of our association. We believe that some of these things have been accomplished. As in any endeavor one never feels that he has accomplished all that he might have. We must realize, however, that most advancements come by evolution.

It was hoped that a definite program could be inaugurated to help rural communities and new doctors to get together, thereby fulfilling a great need. But the Korean war has taken any surplus physicians who might be interested in such locations. Much information has been acquired, however, so that in due time the association should be able to be of considerable service in this connection.

It is no secret that Socialized Medicine almost became a reality. For the present this threat is at least postponed, but the planners are patient and persistent people. None can deny that if physicians were not organized and that if the American Medical Association and the various state associations had not taken up this battle, we would have been taken into camp by Mr. Ewing and his peculiar brand of patriots. Our Coordinating Committee deserves great credit for its effort in our behalf. Organized medicine has done a real job for freedom-loving Americans. Organized medicine deserves your support—not just a few of your dollars—it deserves your active personal efforts in its behalf. It is time we begin to **live** Americanism—to be **for** something if we are to survive.

The American Medical Association requested that we obtain resolutions from various organizations of our state expressing their disapproval of Socialized Medicine, and we are proud to report that Indiana leads all the states in this drive. We have sent more than two thousand such resolutions to our Federal officials. This is more than twice the number from any other state and represents about 20 percent of those obtained in the entire country. Our Auxiliary deserves much credit in this program.

A most unhappy but real responsibility we doctors have is to clean our own house. It is heartening to know that such a large part of our profession does practice by the Golden Rule. But it must not be ignored that a small number of our membership does untold harm by overcharging and otherwise mistreating the people. These offenders must be made to realize the damage they do to our profession and to all of democracy. People expect and deserve good treatment from our profession.

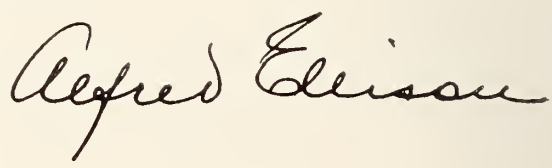
During the year considerable progress has been made in bringing about better understanding between hospitals and the physicians who practice in them. It has been emphasized that it is unethical for a hospital to employ a physician on a salary and to resell his services for a fee. This fundamental principle of ethics must never be abandoned. When we drift away from such principles we will cease to be a profession.

Great interest has been created by the postgraduate telephone educational series, and during this year almost one-half of the county societies of the state cooperated in receiving these telephone broadcasts, carried out in collaboration with our Indiana University School of Medicine. This program has great promise of bringing excellent graduate education to our members over the state.

One of the outstanding accomplishments of our Rural Health Committee has been to stimulate an interest in our state organization by means of a series of meetings which have been held in four areas of the state. It hardly needs emphasizing that every doctor in Indiana should be proud of and take an active part in the democratic medical organizations to which he belongs.

Some may have thought that our emphasis of our responsibilities as citizens was overdone. I wish I could have made it stronger. At no time in our history has it been so important to be good Americans first and good doctors or bakers or bankers second. The very liberties which our recent ancestors won for us at so great a sacrifice are slipping from us at an alarming rate. A continuation of our present program will find us slaves of a socialist state within fifty years. The planner's blueprint for our enslavement is a matter of record. Most of us are too complacent or are too apathetic to raise our voices. America was not founded by such weaklings and it will never be preserved by them. Apathy can mean our destruction. Apathy and democracy cannot survive together.

There are thirty-eight committees currently active in our state association. Each of them has worked faithfully and effectively, for which I express my humble appreciation. Unselfish service in your interest is their highest ambition and selfishness has little place in their thoughts. Let me assure you that next year your affairs will be in strong hands. After fourteen years of activity in our association, one develops friendships which are an important part of his life. It is from such friends that one gains so much by example and inspiration. I salute those who carry on as I say good-bye.



Medical Panorama by the Associate Editor

MODERN CHARITY: ASSEMBLY LINE TYPE

Below is a rather long quotation from an editorial in *The Journal of the Kansas Medical Society* for August, 1951. It presents about two-thirds of the original and is difficult to condense further. The reasons expressed for its original publication are sufficiently cogent for us to reprint it in part:

FEDERATED FUND RAISING

Editor's Note. This editorial on a much discussed subject was prepared by request by a person experienced in fund raising campaigns.

There is a lot of talk these days about "federated" fund raising. If the issue hasn't been raised in your community as yet, it's a 100 to one shot that it will be, and you, more than likely, will be asked to express an opinion on how you feel about it.

The idea of the "federated drive" is based on the principle that all charitable, educational, and health agencies, which now raise their funds through separate and independent financial campaigns, could all be lumped together into a once-a-year, super-community chest which would raise enough money for everything and everybody. The proponents of this idea, aided, abetted, and encouraged by the National Council of Community Chests and Councils, point out that such a plan would (1) eliminate the so-called "bother" to the average business and professional man of being solicited for a worthy cause at every whip-stitch, and (2) that it would protect the relatively small group of public-spirited citizens in each community who are called to work on independent drives several times during the year.

The idea seems like a good one on first glance, but it is being questioned by an equally sincere group of citizens who feel that there may be more involved in the problem than meets the eye. The resistance movement is being headed for the most part by the "national voluntaries" which includes the Red Cross, the American Cancer Society, the National Foundation for Infantile Paralysis, and the National Tuberculosis Association.

Since the medical profession was primarily responsible for bringing into being at least three of these organizations, and since, as in the case of the American Cancer Society, at least half of the members of the governing boards are doctors, it might be well to take a look at their point of view.

There are numerous reasons why these national organizations feel responsible for maintaining their separate identities in fund raising, the most important one being the devitalization of agency activity when they are required to join with many other organizations. It has been the experience of all these organizations that when fund raising responsibility for any given cause is taken away from the agency, the interest in the cause disintegrates and the volunteers rapidly lose interest.

* * *

Another strong argument against the single, united fund campaign is that it cannot possibly include all the financial appeals which will arise during the course of a year. Most local communities have a community chest drive in the fall which raises money for local welfare and recreational needs. In addition, the polio drive in January, the Red Cross drive in March, and the Cancer Crusade in April, are the only appeals which are organized on a personal solicitation basis. Even if all these organizations were included in a federated drive, they would constitute only a small portion of the appeals which the average business man is called on to support. The various local organizations such as churches and youth groups would still be free to "bother" the business man for their own particular appeals for funds.

Therefore, any self-constituted group which attempts to organize an all-inclusive campaign faces a much greater responsibility than the relatively simple task of raising money. They virtually promise their constituency that no other requests for funds will be made. In making such a promise, they imply a control over the free choice of the people as to how, to whom, and when they can give of their means as an expression of their interest in a given cause or program. Most Americans believe that people should have the right to decide for themselves what they will give, and how much; and that no organization, no matter how wise and efficient it may be, should take upon itself the power to compel people to give other than in accordance with their own wishes.

* * *

Obviously there are two sides to this problem, and both sides are going to need patience and flexibility to reach an amicable agreement. We call these points to your attention in order that you may be aware of some of the basic principles involved when you are called on to express an opinion or to be a member of a planning group in your community.

We have thought about this a good many times and cannot help being reminded of the old quotation: "The gift without the giver is bare,"—or words to that effect. It seems not too much different from taxation.

TEST FOR SYPHILIS IN PREGNANT WOMEN

ALBERT STUMP*

INDIANAPOLIS

From the number of inquiries that have come to me regarding the law on the requirements for tests to be made for syphilis in pregnant women, it would seem appropriate to publish the few sections of the public health code adopted in 1949 covering that subject. The pertinent sections with reference thereto in Burns Indiana Statutes, 1949 Replacement, are as follows:

35-1312. "A physician who diagnoses a pregnancy of a woman shall take or cause to be taken a sample of blood at the time of diagnosis and shall submit the sample to an approved laboratory for a standard serological test for syphilis."

35-1313. "Any person other than a physician who is permitted by law to attend a pregnant woman but who is not permitted by law to take blood specimens, shall cause a sample of the blood of the pregnant woman to be taken by a duly licensed physician, who shall submit the sample to an approved laboratory for a standard serological test for syphilis."

35-1314. "If at the time of delivery positive evidence is not available to show that a standard serological test for syphilis has been made during the pregnancy, the person in attendance at the delivery shall take or cause to be taken a sample of the blood of the woman at the time of the delivery and shall submit the sample to an approved laboratory for a standard serological test for syphilis."

35-1315. The state board shall require in each birth certificate (and stillbirth certificate), in addition to information otherwise required in the certificate, information concerning the serological test for syphilis as follows:

"1. Whether a test for syphilis was made for the woman who bore the child.

"2. If the test was made, the date when the blood specimen was taken.

"3. If the test was made, whether it was made during pregnancy or at the time of delivery.

"4. If the test was not made, the reason why the test was not made."

35-1316. "A person who prepares a birth cerificate or a stillbirth certificate shall include such information concerning the serological test for syphilis made for the woman who bore the child."

* Attorney for Indiana State Medical Association.

Detach, fill in bottom line, and display in office or on office door

Doctor Is Out

He is attending the 102nd Annual Session of the Indiana State Medical Association at Indianapolis, where he is hearing scientific lectures by the nation's leading scientists and viewing the latest medical and surgical techniques and equipment by movies and exhibits.

Doctor will be in his office.....

One Hundred And Second

Annual Session

Indiana State Medical Association

Indianapolis, Indiana

October 29, 30 and 31, 1951

Headquarters—Murat Temple

Complete Program on following pages



ALFRED ELLISON, M.D.

South Bend

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INDIANA STATE MEDICAL ASSOCIATION

1950-51

INDIANA STATE MEDICAL ASSOCIATION

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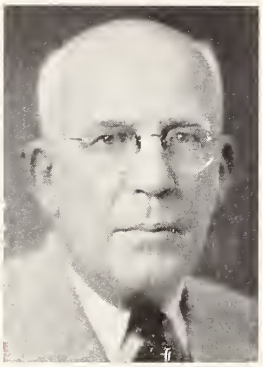
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THE JOURNAL
Hammond



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Editor
THE JOURNAL
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A. W. CAVINS
Associate Editor
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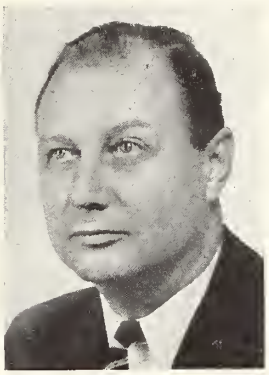
CYRUS J. CLARK
Executive Committee
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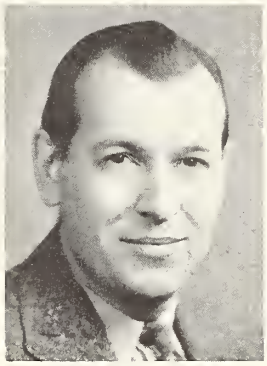
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Field Secretary
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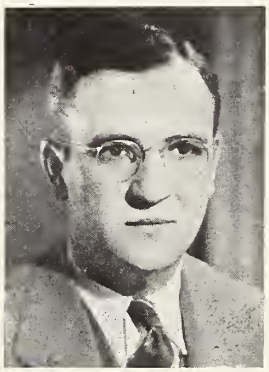
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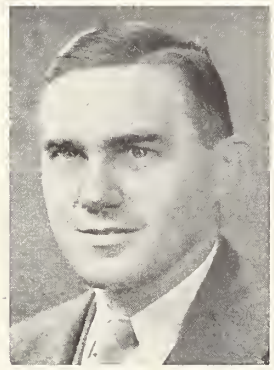
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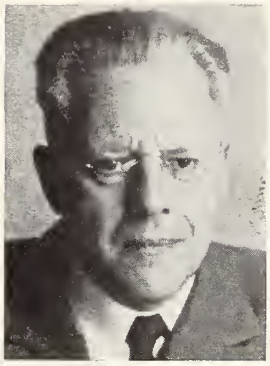
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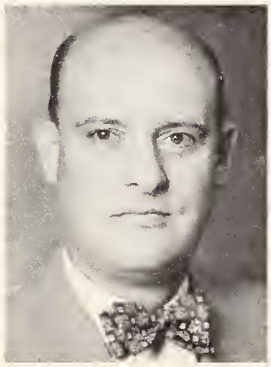
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Section on Ophthalmology
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Indianapolis



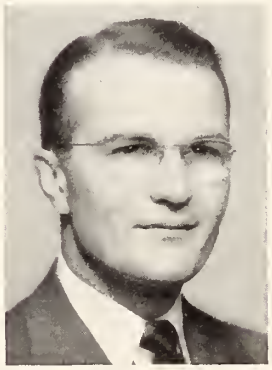
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VIRGIL K. STOELTING
Secretary
Section on Anesthesia
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Evansville



RAYMOND F. CARMODY
Editorial Board
Gary

Meet the Speakers



Andrew C. Offutt, M.D., Indianapolis. Born in Indiana in 1910. M.D., Indiana University School of Medicine, 1940. Director, Communicable Disease Division, Indiana State Board of Health.



James R. McVay, M.D., Kansas City, Missouri. Chairman, Council on Medical Service, A.M.A. Born in 1891; M.D., Johns Hopkins University School of Medicine, Baltimore, 1915.



George F. Lull, M.D., Chicago, secretary and general manager, American Medical Association. Born March 10, 1887, Scranton, Pennsylvania; M.D., Jefferson Medical College, 1909; M.P.H., Harvard Medical School, 1921; D.P.H., University of Pennsylvania, 1922; demonstrator, morbid anatomy, Jefferson Medical College, 1910-12; entered U. S. Army as first lieutenant, 1912; rose to Major General, 1943; served as deputy surgeon general; decorated with Purple Heart, Distinguished Service Medal, and the French Government's Legion of Honor Medal; Fellow of American College of Surgeons, American College of Physicians, and American Public Health Association.

Frederic W. Taylor, M.D., Indianapolis. Born in Indianapolis in 1902. M.D., Columbia University College of Physicians and Surgeons, 1927. Associate professor of surgery, Indiana University School of Medicine. Consultant Veterans Hospital; staff: Indianapolis General Hospital, Indiana University Hospitals, Methodist and St. Vincent's hospitals.

(Photograph not received)



Joseph C. Bell, M.D., Louisville, Kentucky, associate professor of roentgenology, University of Louisville School of Medicine, and president-elect of Radiological Society of North America. Born in 1892, Punxsutawney, Pennsylvania; M.D., Harvard Medical School, 1923; served in World War I; re-entered Army in 1942 as chief of x-ray department, Percy Jones General Hospital; held rank of lieutenant colonel when placed on inactive service, 1945; heads x-ray department, Norton Memorial Infirmary; radiologist consultant, Kosair Crippled Children Hospital and State Tuberculosis Sanatorium; senior consultant, U. S. Veterans Hospital, Louisville; author of many articles.



William M. Tuttle, M.D., Detroit, associate professor of clinical surgery, Wayne University College of Medicine. Born in 1905, Philadelphia. M.D., University of Chicago School of Medicine, 1932; served 1942-45 with U. S. Army, holding rank of lieutenant colonel when discharged; engages in private practice of thoracic surgery; Chief of Thoracic Surgery at Harper Hospital; associate surgeon, Herman Kiefer Hospital, Receiving Hospital and Detroit Tuberculosis Sanitarium; has written extensively on thoracic surgery and related subjects. Secretary-Treasurer of the Board of Thoracic Surgery.



Carroll S. Wright, M.D., Philadelphia, Pennsylvania, professor of dermatology and syphilology, Temple University School of Medicine. Born in 1895 in Freeport, Michigan; M.D., University of Michigan Medical School, 1919; professor of clinical dermatology and syphilology, Graduate School of Medicine, University of Pennsylvania; consultant in dermatology at Philadelphia Municipal Hospital, Shriner's Hospital, St. Christopher's Children's Hospital, Pennsylvania Institute for the Blind and Vineland Training School. Contributor to scientific journals and various textbooks.



Khalil G. Wakim, M.D., Rochester, Minn., professor of clinical physiology and research consultant, Mayo Foundation and Mayo Clinic. Born in 1907 in Sidon, Lebanon; M.D., American University, Beirut, Lebanon, 1933; Ph.D., Mayo Clinic and University of Minnesota, 1941; instructor in American University, 1933-37; studied health conditions among nomadic tribes in Syria, 1937; came to United States in 1938 and naturalized in 1943; medical fellow in physiology, Mayo Clinic, 1938-1941; associate professor of physiology, Indiana University, 1941-43; professor of physiology, Indiana University, 1943-46; expert consultant to surgeon general of U. S. Army. Frequent contributor of articles to scientific journals.



Walter F. Kammer, M.D., Muncie. Born in Wisconsin in 1913. M.D., Rush Medical College, Chicago, 1938. Consultant in cardiology, Muncie Clinic; certified, American Board of Internal Medicine; associate, American College of Physicians.



John A. Shively, M.D., fellow in Clinical Pathology at South Bend Medical Foundation. Born in Indiana in 1922. M.D., Indiana University School of Medicine, 1946; interned Philadelphia General Hospital; spent two years in Army; resident in internal medicine Caylor-Nickel Clinic, Bluffton; fellow in Clinical Pathology, Indiana University School of Medicine.

Joseph E. Coleman, M.D., Evansville. Born in Illinois in 1921. M.D., Indiana University School of Medicine, 1944. Member, American Board of Pediatrics.

(Photograph not received)



Willis D. Gatch, M.D., Indianapolis. Born in Indiana in 1878; M.D., Johns Hopkins University School of Medicine, 1907. Formerly dean, and chairman, Department of Surgery, Indiana University School of Medicine. Author of numerous articles on intestinal obstruction.



S. Robertson Mercer, M.D., Fort Wayne. Born in Pennsylvania in 1902. M.D., University of Pittsburgh, 1928; two years postgraduate work, Mayo Clinic, one year, New York Skin and Cancer Hospital. Fellow American College Physicians; fellow Academy Dermatology and Syphilology.



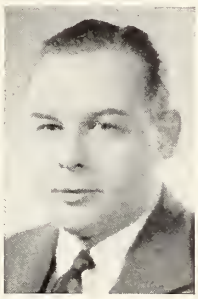
Edward G. Waters, M.D., F. A. C. S., Jersey City, New Jersey. Born in Derby, Connecticut, 1898. Graduate of Yale University, 1919, and Harvard Medical School, 1922. Division Chief of Obstetrics, Margaret Hague Maternity Hospital, Jersey City, New Jersey, for past 20 years; assistant clinical professor of Obstetrics and Gynecology, Columbia University, New York, for fifteen years; attending surgeon at Christ and Fairmount Hospitals, Jersey City, New Jersey; consulting gynecologist at Paterson General Hospital and Monmouth Memorial Hospitals; consultant staff, gynecology, St. Mary's Hospital, Passaic, New Jersey. Author of numerous scientific papers.



Geza deTakats, M.D., Chicago, clinical professor of surgery, University of Illinois College of Medicine. Born in 1892 in Budapest, Hungary. M.D., University of Budapest, 1915. M.S. in surgery, University of Budapest, 1918. Taught surgery at Budapest. In 1924 he was special Fellow at Mayo Clinic; has engaged in general surgery in Chicago since 1925; is former assistant professor of surgery, Northwestern University Medical School; author of many articles.



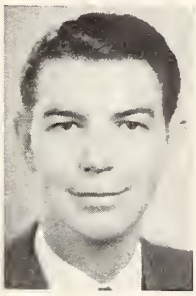
Hugh A. Kuhn, M.D., Hammond. Born in 1895 in Ohio; M.D., University of Cincinnati Medical College, 1921. Member American Academy of Ophthalmology and Otolaryngology, American Society of Ophthalmological and Otolaryngological Aliergy, American College of Allergists, International College of Surgeons, American Laryngologic, Rhinologic and Otologic Society, Hansel Foundation of St. Louis, Kansas City Anatomical Society, American Boards of Ophthalmology and Otolaryngology. Author of many articles.



Robert L. Patterson, M.D., Pittsburgh, Pennsylvania; attending anesthesiologist, Allegheny General Hospital; associate professor anesthesiology, University of Pittsburgh School of Medicine. Born in Jeannette, Pennsylvania, 1909. M.D., Jefferson Medical College, 1935; interned, the Hospital of the Protestant Episcopal Church, Philadelphia, 1936-1938; residency in anesthesiology, Hartford Hospital, Hartford, Connecticut, 1938-1940.



Rachmiel Levine, M.D., Chicago. Born in 1910; M.D., McGill University, 1936; fellowship in Internal Medicine, McGill University, 1936; research fellow, department of Metabolic and Endocrine Research, Michael Reese Hospital 1936-1939; assistant director 1939-1943; director 1943 to present. Attending physician and professorial lecturer in physiology, University of Chicago, 1947 to present. Author of numerous scientific articles.



James S. Browning, M.D., Indianapolis, assistant professor of medicine, Indiana University School of Medicine, consultant in medicine, Cold Spring Road Veterans Hospital. Born in 1908 in Indiana; M.D., Indiana University School of Medicine, 1935.



William D. Robinson, M.D., Ann Arbor, Michigan, associate professor of internal medicine, University of Michigan Medical School. Born in 1911 in Hoosac, New York; M.D., University of Michigan Medical School, 1934; research fellow, University of Michigan Medical School, 1936-38; with International Health Division, Rockefeller Foundation, 1940-43; instructor in medicine, Vanderbilt University School of Medicine, 1940-43; in charge of Rackham Arthritis Research, University of Michigan Medical School.



Alan C. Woods, M.D., Baltimore, Maryland, Professor of Ophthalmology, Johns Hopkins University School of Medicine. Born in 1889 in Baltimore; M.D., Johns Hopkins University School of Medicine, 1914; taught ophthalmology in Johns Hopkins for twenty-one years; director of Wilmer Ophthalmology Institute; served in World War I, holding rank of major when discharged; author of many scientific papers.



Oliver Cope, M.D., Boston, Massachusetts, associate professor of surgery, Department of Surgery of the Harvard Medical School at Massachusetts General Hospital. Born in 1902 in Philadelphia; M.D., Harvard Medical School in 1928; residency in surgery from 1928 to 1932 at the Massachusetts General Hospital. In 1933 and 1934 he had a Moseley Traveling Fellowship in Europe.



William D. Province, M.D., Franklin. Born in Indiana in 1910. M.D., Columbia University College of Physicians and Surgeons, New York, 1936. Consultant, U. S. Army Hospital, Camp Atterbury; fellow American College of Physicians.

Official Program

One Hundred and Second Annual Session

INDIANA STATE MEDICAL ASSOCIATION

Murat Temple

Indianapolis, Indiana

October 29, 30, 31, 1951

Monday, October 29, 1951

Morning

8:00 a.m. Registration starts, lounge room, Murat Temple.

9:00 a.m. Opening of technical and scientific exhibits, lounge room, Murat Temple.

10:00 a.m. Annual golf tournament. Medal play, based on low gross and handicap. Meridian Hills Country Club.

10:00 a.m. Annual trap shoot, Indiana Gun Club.

10:00 a.m. Editorial Board meeting, Officers' Room, Murat Temple.

11:00 a.m. Instructional courses, Murat Temple.

11:00 a.m. Council meeting, Blue Room, Athenaeum. Luncheon at 12:30 p.m.

12:00 m. Luncheon meeting of Committee on Mental Health, Veterans' Room, Athenaeum. (Meeting open to all those interested in mental health.)

Afternoon

1 to 5 p.m. Instructional courses, Murat Temple.

3:00 p.m. Meeting of House of Delegates, Little Auditorium, Athenaeum. (All association members are welcome.)

Evening

6:00 p.m. Reception and annual dinner meeting for women physicians, Indianapolis Athletic Club. (Dinner at 6:30.)

7:00 p.m. Buffet supper, smoker and stag party, Egyptian Room, Murat Temple. (Dining room open at 6:00 p.m. Tickets $2.00.)

Tuesday, October 30, 1951

Morning

7:30 a.m. Breakfast meeting of Committee on Veterans Affairs and Rehabilitation, third floor, Columbia Club.

8:00 a.m. Registration continues, lounge room, Murat Temple.

8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple.

10:00 a.m. Meeting of Indiana Association of Pathologists, Blue Room, Athenaeum.

GENERAL MEETING

Murat Theater

9:00 a.m. Call to order by Alfred Ellison, M.D., South Bend, president, Indiana State Medical Association.

9:00 a.m. Greetings by Earl W. Mericle, M.D., Indianapolis, president of Indianapolis Medical Society, and J. Neill Garber, M.D., Indianapolis, chairman of Committee on Convention Arrangements.

9:10 a.m. ANDREW OFFUTT, M.D., director of Communicable Disease Division, Indiana State Board of Health, Indianapolis.
Subject: *"The Doctor's Role in Community Defense."*

9:30 a.m. JAMES R. McVAY, M.D., Chairman, Council on Medical Service, American Medical Association, Kansas City, Missouri.
Subject: *"A Doctor Looks at Public Relations."*

9:50 a.m. GEORGE F. LULL, M.D., secretary and general manager, American Medical Association, Chicago.
Subject: *"What the American Medical Association Is Doing with Your Dues."*

10:20 a.m. JOSEPH C. BELL, M.D., Associate Professor of Roentgenology, University of Louisville School of Medicine, Louisville, Kentucky.
Subject: *"The Diagnosis of Malignant and Potentially Malignant Lesions of the Colon and Rectum."*

10:45 a.m. Thirty-minute intermission to view technical and scientific exhibits.

(Tuesday, October 30, 1951)

11:15 a.m. WILLIAM M. TUTTLE, M.D., Associate Professor of Clinical Surgery, Wayne University College of Medicine, Detroit.
Subject: *"The Mimicry of Carcinoma of the Lung."*

11:40 a.m. CARROLL S. WRIGHT, M.D., Professor of Dermatology and Syphilology, Temple University School of Medicine, and Professor of Clinical Dermatology and Syphilology, Graduate School of Medicine, University of Pennsylvania, Philadelphia. (Brayton Foundation speaker.)
Subject: *"The Detection of Causes in Contact Dermatitis."*

Noon

12:00 m. Luncheon meeting of members of State and County Tuberculosis Committees, Directors' Room, Athenaeum. Indiana Chapter of American College of Chest Physicians participating.
Speakers:
WILLIAM M. TUTTLE, M.D., Detroit.
"Unusual Lung Conditions."
JAMES H. STYGALL, M.D., Indianapolis.
Report on case of Pulmonary Histoplasmosis in an Adult.
REID L. KEENAN, M.D., Indianapolis.
"Tuberculosis of the Bone."
X-ray conference.

12:05 p.m. Luncheon meeting, Indiana Academy of General Practice, Kellersaal, Athenaeum.
Speaker: LEE PENNINGTON, Washington Office of the Federal Bureau of Investigation.
Subject: "Your FBI."

12:15 p.m. Phi Rho Sigma luncheon meeting, Kneipe Room, Murat Temple.

12:30 p.m. Luncheon meeting, Indiana Roentgen Society, Fraternity Room, Athenaeum.
Speaker: JOSEPH C. BELL, M.D., Louisville.

Afternoon

GENERAL MEETING

Murat Theater

2:00 p.m. GENERAL SUBJECT: *"Fluid and Electrolyte Balance."*
KHALIL G. WAKIM, M.D., Professor of Clinical Physiology, University of Minnesota Graduate School, Minneapolis-Rochester.
Subject: *"Physiological Basis."*

2:30 p.m. FREDERIC W. TAYLOR, M.D., Indianapolis.
Subject: *"Surgical Application."*

2:50 p.m. WALTER F. KAMMER, M.D., Muncie.
Subject: *"Medical Application."*

3:10 p.m. Thirty-minute intermission to view technical and scientific exhibits.

(Tuesday, October 30, 1951)

3:40 p.m. GENERAL SUBJECT: *"Fluid and Electrolyte Balance."*
JOHN A. SHIVELY, M.D., South Bend.
Subject: *"Practical Application."*

4:00 p.m. SYMPOSIUM on *"Fluid and Electrolyte Balance."*
Moderator: W. D. GATCH, M.D., Indianapolis.
Participants: KHALIL G. WAKIM, M.D., Rochester, Minnesota.
FREDERIC W. TAYLOR, M.D., Indianapolis.
WALTER F. KAMMER, M.D., Muncie.
JOHN A. SHIVELY, M. D., South Bend.

4:45 p.m. Meeting of Section on Medicine, Dining Room, Murat Temple. Election of section officers for 1952.

4:45 p.m. Meeting of Section on General Practice, Murat Theater. Election of section officers for 1952.

4:45 p.m. Time allowed to view technical and scientific exhibits.

Evening

6:00 p.m. Dinner meeting and reunion of class of 1934 of Indiana University School of Medicine, Indianapolis Athletic Club. (Bring your wife.)

8:00 p.m. President's Night. Murat Theater.
Address, ALFRED ELLISON, M.D., South Bend, President.
"The Doctor's Place In the Sun."
Concert: Purdue University Varsity Glee Club.

Wednesday, October 31, 1951

Morning

7:30 a.m. Breakfast meeting of Committee on Conference of County Medical Society Officers, Columbia Club.

8:00 a.m. Registration continues, lounge room, Murat Temple.

8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple.

GENERAL MEETING

Murat Theater

9:30 a.m. SAMUEL R. MERCER, M.D., Fort Wayne.
Subject: *"Skin Cancer."*

9:50 a.m. EDWARD G. WATERS, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, Jersey City, New Jersey.
Subject: *"Medical and Surgical Treatment for Parturitional Hemorrhage."*

(Wednesday, October 31, 1951)

10:15 a.m. GEZA deTAKATS, M.D., Clinical Professor of Surgery, University of Illinois College of Medicine, Chicago.
Subject: *"The Surgical Treatment of Hypertension."*

10:40 a.m. Thirty-minute intermission to view technical and scientific exhibits.

11:10 a.m. HUGH A. KUHN, M.D., Hammond.
Subject: *"Allergy of the Ear and Allergic Deafness."*

11:30 a.m. ROBERT L. PATTERSON, M.D., Associate Professor of Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh.
Subject: *"The Medical Preparation of a Patient for Anesthesia."*

11:55 a.m. Meeting of Section on Surgery, Murat Theater. Election of section officers for 1952.

11:30 a.m. Final meeting of House of Delegates, Little Auditorium, Athenaeum.

Luncheon at 12:30 p.m., Kellersaal, Athenaeum. (All members welcome to meeting in Auditorium. Luncheon for delegates only.)

Meeting of Council immediately following adjournment of House of Delegates.

Noon

12:00 m. Luncheon meeting of Section on Obstetrics and Gynecology, Blue Room, Athenaeum.
Speaker: EDWARD G. WATERS, M. D., Jersey City, New Jersey.
Moderator: G. W. GUSTAFSON, M.D., Indianapolis. Obstetrical round table discussion.
Election of section officers for 1952.

12:00 m. Luncheon meeting of Committee on Industrial Health of the Indiana State Medical Association and Medical Appointees of the Indiana Bell Telephone Company, Ladies Dining Room, Athenaeum. Host, Indiana Bell Telephone Company.
Speaker: MELVILLE H. MANSON, M.D., Medical Director, American Telephone and Telegraph Company, New York.
Subject: *"Problems Relating to Employees' Benefit Plan."*

12:00 m. Phi Beta Pi luncheon, East Room, Athenaeum.

(Wednesday, October 31, 1951)

12:30 p.m. Luncheon meeting of Section on Anesthesia, Fraternity Room, Athenaeum.
Speaker: ROBERT L. PATTERSON, M.D., Pittsburgh.
Subject: *"The Effects of Protein Balance on the Maintenance of a Normal Electrolyte Balance."*
Election of section officers for 1952.

Afternoon

GENERAL MEETING

Murat Theater

2:00 p.m. GENERAL THEME: *"Pituitary Adrenal Mechanism and Therapeutic Use of ACTH and Cortisone."*
RACHMIEL LEVINE, M.D., Professorial Lecturer in Physiology, University of Chicago, Chicago, Illinois.
Subject: *"The Physiological Effects of the ACTH-Adrenocortical System."*

2:25 p.m. WILLIAM D. ROBINSON, M.D., Associate Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan.
Subject: *"Arthritis Aspect."*

2:50 p.m. ALAN C. WOODS, M.D., Professor of Ophthalmology, Johns Hopkins University School of Medicine, Baltimore.
Subject: *"Use of ACTH and Cortisone in Ophthalmology."*

3:15 p.m. Thirty-minute intermission to view technical and scientific exhibits.

3:45 p.m. OLIVER C. COPE, M.D., Associate Professor of Surgery, Harvard Medical School, Boston.
Subject: *"Burns and Shock."*

4:10 p.m. ROUND TABLE DISCUSSION:
Moderator: WILLIAM D. PROVINCE, M.D., Franklin.
Participants: JAMES S. BROWNING, M.D., Indianapolis.
JOSEPH E. COLEMAN, M.D., Evansville.
RACHMIEL LEVINE, M.D., Chicago.
WILLIAM D. ROBINSON, M.D., Ann Arbor.
ALAN C. WOODS, M.D., Baltimore.
OLIVER C. COPE, M.D., Boston.

4:55 p.m. Time allowed to view technical and scientific exhibits.

(Wednesday, October 31, 1951)

4:55 p.m. Meeting of Section on Ophthalmology and Otolaryngology, Officers' Room, Murat Temple. Election of section officers for 1952.

5:00 p.m. Reception for members of Fifty Year Club, Lincoln Room, Lincoln Hotel.
Entertainment: RICHARD F. MILLS, Indianapolis.
STEPHEN FOSTER QUARTET.

Evening

6:30 p.m. Annual dinner and dance, Indiana Ballroom.
Presiding officer, ALFRED ELLISON, M.D., president, Indiana State Medical Association.

(Wednesday, October 31, 1951)

Recognition of Fifty Year Club members,

Award to General Practitioner of the Year.

Speakers:

LOUIS H. BAUER, M.D., president-elect, American Medical Association, Hempstead, N.Y.

SENATOR KARL E. MUNDT, Madison, South Dakota.

Presentation of certificate of merit and plaque to ALFRED ELLISON, M.D., president 1951, by J. William Wright, M.D., president, 1952.

Women's Entertainment

Monday, October 29, 1951

8:00 a.m. Registration starts, lounge room, Murat Temple. (Purchase your luncheon and dinner tickets when you register.)

6:30 p.m. Dinner, honoring past presidents of Woman's Auxiliary to the Indiana State Medical Association, Ballroom, Indianapolis Athletic Club.



Speaker: WILLIE SNOW ETHRIDGE.



Concert Pianist:
CATHERINE SAURER SMITH.

Tuesday, October 30, 1951

8:00 a.m. Registration continues, lounge room, Murat Temple.

9:30 a.m. Meeting of Councilor District Chairmen, Green Room, Indianapolis Athletic Club.

10:00 a.m. Board meeting, Woman's Auxiliary to the Indiana State Medical Association, Green Room, Indianapolis Athletic Club.

12:30 p.m. Luncheon, Ballroom, Indianapolis Athletic Club. Door prizes!!



Speaker: MRS. HAROLD F. WAHLQUIST, president, Woman's Auxiliary to the American Medical Association, Minneapolis.

8:00 p.m. Concert, Purdue University Varsity Glee Club, Murat Theater.

Wednesday, October 31, 1951

8:00 a.m. Registration continues, lounge room, Murat Temple.

2:00 p.m. Fashion show and tea, Wm. H. Block Company Auditorium. (Your registration badge will admit you.)

6:30 p.m. Annual dinner and dance in conjunction with the Indiana State Medical Association, Indiana Ballroom.

Semiannual Conference of

INDIANA STATE BOARD OF HEALTH

with

LOCAL HEALTH OFFICERS

October 28 and 29, 1951

Rice Auditorium

State Board of Health Building

1330 West Michigan

Indianapolis

PROGRAM

Sunday, October 28

12:00-1:30 P.M. Registration.

Presiding: L. E. Burney, M.D.

1:30-2:00 Proposed Changes in Communicable Disease Regulations.

2:00-2:30 Discussion of Communicable Disease Regulations.

2:30-2:35 Protection of Certified Copies of Birth Records by Robert Yoho.

2:35-3:30 Panel on Civil Defense

A. C. Offutt, M.D., — Bacteriological Warfare.

Gerald F. Kempf, M.D.—The Responsibilities of Public Health in Civil Defense.

Perry Miller—Radiological and Chemical Warfare.

T. E. Sullivan—Food and Drugs.

George Fassnacht—Water.

3:30-3:45 Intermission.

Meeting of

Indiana Health Officers' Association

Presiding: Morris Balla, M.D., President

3:45-4:30 General Discussion of Civil Defense Problems and other Public Health Problems.

4:30-5:00 Committee Reports.

Monday, October 29

8:30 A.M. Health Officers' Breakfast, Lincoln Hotel, Lincoln Room (14th floor).

Business Session.

Election of Officers.

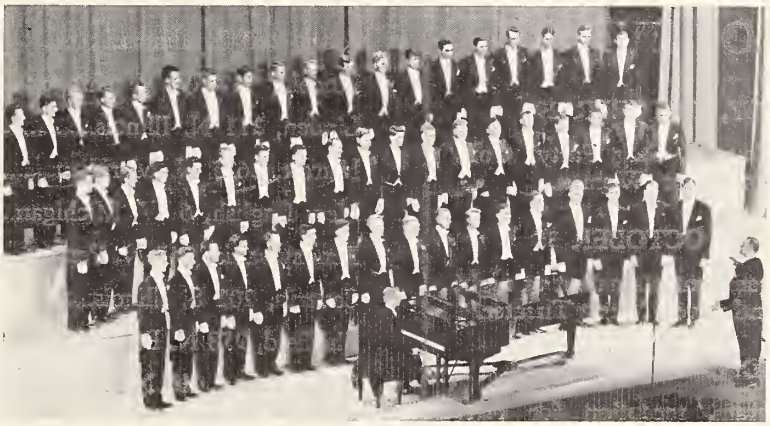
Section of State Medical Association on Preventive Medicine.

Free and Informal Discussion.

ENTERTAINMENT
OCTOBER 29-30-31

THE various committees in charge of entertainment for the annual convention of the Indiana State Medical Association have arranged a group of activities which should keep all visiting physicians and their wives in the best of spirits during the three days of the convention. The program at press time is definite enough to give you the following tempting information.

Monday morning the early arrivals and outdoor men may choose between the Golf Tournament at the Meridian Hills Country Club or the Annual Trapshoot at the Indiana Gun Club. Both events are scheduled for 10:00 A.M. The convention certainly promises to start with a bang.



Purdue University Varsity Glee Club

The buffet supper and stag will get under way on Monday evening at 7:00 P.M. in the Egyptian Room of the Murat Temple; refreshments will be served at 6:00 P.M. An outstanding group of entertainers will journey to our fair city from Chicago to make this a big night for all. The star attraction of the evening will be a magician of world reknown who will entertain and confuse with his famous bag of tricks.

During the stag and buffet supper an excellent evening of entertainment has been arranged for all physicians' wives in the Indianapolis Athletic Club Ballroom. Dinner at 6:30 P.M. is in honor of the past presidents of the Woman's Auxiliary to the Indiana State Medical Association. The principal speaker will be Willie Snow Ethridge, author of famous best sellers, who will entertain in her humorous manner. Concert pianist Catherine Saurer Smith will complete the evening's entertainment.



Senator Mundt

Tuesday evening will provide an outstanding evening of musical entertainment in the Murat Theater. The Purdue University Varsity Glee Club, under the direction of Mr. Albert Stewart, will entertain in the manner which has made this organization so famous. This truly promises to be an enjoyable program and one you can't afford to miss.

Wednesday afternoon will feature an attraction which should delight all of the ladies and possibly worry their husbands a little. A Fashion Show and Tea in the Wm. H. Block Auditorium at 2:00 P.M. will provide entertainment which cannot help but please those present.

The three-day round of activities will come to an end in a fitting manner on Wednesday at 6:30 P.M. in the Indiana Ballroom. Dr. Alfred Ellison, the president of the Indiana State Medical Association, will preside at the annual dinner. The program will include such activities as the presentation of the award to the "General Practitioner of the Year"; the recognition of physicians who have practiced for fifty years; and the presentation of the past president's award by Dr. J. Wm. Wright, the president for 1952.

Speakers at the dinner will be Louis H. Bauer, M.D., the president-elect of The American Medical Association, and Senator Karl E. Mundt from Madison, South Dakota. Both speakers will have messages which should be of great interest to all present. We may feel fortunate indeed to be able to present such a dual attraction on the closing day of the convention.

Enjoyable dinner music has been arranged, and Tommy Moriarity and his fourteen-piece orchestra will play for dancing. A floor show headed by Joe Wallace as master of ceremonies will include The Malone Sisters and Curry, Byrd, and Leroy in a show featuring comedy, dancing and music, all of which should round out the three days of entertainment in a grand manner.



Doctor Bauer

NEED A HOTEL RESERVATION FOR THE STATE MEETING?

(Indianapolis, October 29, 30, 31, 1951)

Start Calling Doctor Gillespie!

Don't stay at home because you haven't a hotel room for the I.S.M.A. convention—**Dr. Jacob E. Gillespie and his Housing Committee will get you a room.**

Write to Doctor Gillespie . . . **not to a hotel** . . . if you need a room. Use form below.

TIME OF EVENTS

MONDAY, OCTOBER 29

Instructional Courses, Stag Party, Golf, Trapshoot, Party for Women.

TUESDAY, OCTOBER 30

Scientific Program, entertainment at night for doctors and wives, Murat Theater.

WEDNESDAY, OCTOBER 31

Scientific Program, reception for Fifty Year Club, annual dinner and dance.

Hotels	Rates (Start) Single	Double
Antlers, 750 N. Meridian	$4.25	$6.25
Barnes, 233 McCrea Place	$2.50	$3.50
Barton, 505 N. Delaware	$2.75	$4.00
Claypool, 14 N. Illinois	$4.60	$6.30
Harrison, 51 N. Capitol	$3.75	$5.75
Jones, 248 S. Illinois	$2.50	$4.50
Lincoln, 117 W. Washington	$4.00	$6.25
Linden, 311 N. Illinois	$2.00	$3.50
Marott, 2625 N. Meridian	$6.00	$8.00
New English, 6 W. Michigan	$2.00	$3.00
Pennsylvania, 947 N. Penn	$3.50	$5.00
Severin, 201 S. Illinois	$4.50	$6.50
Sheffield, 958 N. Pennsylvania	$3.50	$6.00
Spink Arms, 410 N. Meridian	$3.50	$6.00
Warren, 123 S. Illinois	$4.00	$6.00
Washington, 34 E. Washington	$3.50	$5.00

HOTEL RESERVATION BLANK

Clip and Mail this coupon to Dr. Jacob E. Gillespie, 523 Hume Mansur Bldg., Indianapolis 4, Ind.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Indiana State Medical Association, October 29, 30 and 31, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price:.....

☐ Twin Bed Room with bath ☐ Suite

Arrival date .....A. M. .....P. M.

Departure date .....A. M. .....P. M.

Name .....

Address .....

.....

.....

Hotel Choices

First .....

Second .....

Third .....

Fourth .....

ORDER YOUR TICKETS FOR THE 1951 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1951 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at Murat Temple, Indianapolis, is now complete. All classes are on Monday, October 29, 1951.

(Attendance at these classes by members of the Indiana Academy of General Practice will be accepted as postgraduate training credit by that organization.)

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is $1.00 per class with a maximum charge of $3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now! Classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE

Hr.	Room A	Room B	Room C	Room D	Room E	Room F
11 to 12	Bedside and Office Diagnosis of Cardiac and Vascular Problems Course 1	The Psychological Management of Patients Course 2	Pediat ic Problems Course 3	The Newer Drugs Course 4	The Diagnosis and Treatment of Common Skin Diseases Course 5	Corns, Bunions, and Painful Feet Course 6
	NOON RECESS					
1 to 2	The Newer Management of Coronary Disease, Rheumatic Fever, and Congestive Failure Course 7	The Demonstration of A Neurological Examination Course 8	Infant Feeding Problems Course 9	ACTH and Cortisone Course 10	Office Diagnosis and Treatment of Common Genitourinary Condition. Course 11	Minor Home, Farm and Factory Emergencies Course 12
2 to 3	Salt Metabolism in Heart Failure and Hypertension Course 13	The Headache Problem Course 14	Impotence and Infertility Course 15	The Management of Diabetes Mellitus Course 16	Diagnosis and Treatment of Respiratory Diseases Course 17	Management of the Elderly Course 18
3 to 4	The Demonstration of A Physical Examination Course 19	How to Improve Your Own Public Relations Course 20	Obstetrical Emergencies Course 21	Bedside and Office Diagnosis of Cardiac and Vascular Diseases Course 22	The Management of Anorectal Conditions Course 23	Management of The Menopause Syndrome Course 24
4 to 5	The Treatment of Anemias and Allied Conditions Course 25	Management of the Neurotic Course 26	The Diagnosis and Treatment of Common Skin Diseases Course 27	Newer Managements of The Stomach and Bowel Course 28	Diagnosis and Management of Common Gynecological Problems Course 29	The Backache Problem Course 30

Cut on Dotted Line

APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for $1.00; $2.00; $3.00. Please reserve tickets for the following Instructional Courses:

	11:00 A.M.	1:00 P.M.	2:00 P.M.	3:00 P.M.	4:00 P.M.
First choice.....	No.:	No.:	No.:	No.:	No.:
Second choice.....	No.:	No.:	No.:	No.:	No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, October 29, 1951.

Signed: .....M.D.

Address: .....

Announcements

The Section on Medicine will meet at 4:45 p.m. on Tuesday, October 30, in the dining room at the Murat Temple.

The Section on General Practice will meet at 4:45 p.m., in the Murat Theater.

The Section on Surgery will meet at 11:55 a.m. on Wednesday, October 31, in the Murat Theater.

The Section on Obstetrics and Gynecology will have a luncheon meeting at 12:00 noon on Wednesday, October 31, in the Blue Room at the Athenaeum. Dr. Edward G. Waters, of Jersey City, New Jersey, will be the speaker.

The Section on Anesthesia will have a luncheon meeting at 12:30 p.m., on Wednesday, October 31, in the Fraternity Room, at the Athenaeum. Dr. Robert L. Patterson, of Pittsburgh, will be the speaker.

The Section on Ophthalmology and Otolaryngology will meet in the Officers Room at the Murat Temple, at 4:55 p.m., on Wednesday, October 31.

There will be a luncheon meeting of members of **State and County Tuberculosis Committees**, at 12:00 noon on Tuesday, October 30, in the Directors' Room, at the Athenaeum. The Indiana Chapter of the American College of Chest Physicians will participate. Speakers will be Dr. James H. Stygall, and Dr. Reid L. Keenan, both of Indianapolis.

The Annual Golf Tournament will begin at 10:00 a.m., on Monday, October 29, at the Meridian Hills Country Club. This will be a medal play, based on low gross and handicap.

The Annual Trapshoot will be held at 10:00 a.m. on Monday, October 29, at the Indiana Gun Club, near Indianapolis. Each physician wishing to participate must notify Dr. Louis T. Need, 1927 S. Meridian Street, Indianapolis 25, chairman of the Committee on Trapshoot. Reservations for the luncheon also must be made through Doctor Need.

There will be a meeting of the **Editorial Board** of THE JOURNAL at 10:00 a.m., on Monday, October 29, in the Officers' Room of the Murat Temple.

The Phi Beta Pi luncheon will be in the East Room at the Athenaeum at 12:00 noon on Wednesday, October 31.

A reception for members of the **Fifty-Year Club** has been arranged for 5:00 p.m., on Wednesday, October 31 in the Lincoln Room of the Lincoln Hotel. Richard F. Mills, of Indianapolis, will give a humorous talk, and the Stephen Foster Quartet will sing.

The Council will have a luncheon meeting at 11:00 a.m., on Monday, October 29, in the Blue Room at the Athenaeum, and will meet again immediately following the final House of Delegates meeting at 11:30 a.m. on Wednesday, October 31, in the Little Auditorium at the Athenaeum.

The House of Delegates will hold its first meeting at 3:00 p.m., on Monday, October 29, in the Little Auditorium at the Athenaeum. The final meeting will be at 11:30 a.m. on Wednesday, October 31, in the Little Auditorium at the Athenaeum. All association members are welcome at both meetings. Luncheon for delegates only will be at 12:30 p.m., October 31, in the Kellersaal at the Athenaeum.

The Committee on Mental Health will meet at noon on Monday, October 29, in the Veterans' Room at the Athenaeum. The meeting will be open to all those who have questions to ask or material to present, and officials in state mental health affairs will be present to answer questions. Luncheon reservation should be made with Dr. E. Vernon Hahn, chairman of the committee, 914 Hume Mansur Building, Indianapolis 4.

A breakfast meeting of the **Committee on Veterans Affairs and Rehabilitation** will be held at 7:30 a.m., on the third floor of the Columbia Club, on Tuesday, October 30.

A meeting of the **Indiana Association of Pathologists** will be held at 10:00 a.m., on Tuesday, October 30, in the Blue Room of the Athenaeum.

The Indiana Academy of General Practice will have a luncheon meeting at 12:05 p.m., on Tuesday, October 30, in the Kellersaal at the Athenaeum.

The Phi Rho Sigma luncheon meeting will be held at 12:15 p.m., on Tuesday, October 30, in the Kneipe Room at the Murat Temple.

The Indiana Roentgen Society will have a luncheon meeting in the Fraternity Room at the Athenaeum, at 12:30 p.m., on Tuesday, October 30. The speaker will be Dr. Joseph C. Bell, of Louisville.

The Committee on Industrial Health of the state association, and medical appointees of the Indiana Bell Telephone Company will have a luncheon meeting at 12:00 noon on Wednesday, October 31, in the Ladies Dining Room at the Athenaeum. Indiana Bell Telephone is the host, and the speaker will be Dr. Melville H. Manson, of New York.

Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, October 29, 30 and 31, 1951.

The House of Delegates will be constituted as follows: Marion County, seventeen delegates; Lake County, six delegates; Allen County, four delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Jasper-Newton, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates; the other sixty-three county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, F. S. Crockett, J. H. Weinstein, R. L. Sensenich, Herman M. Baker, Karl R. Ruddell, A. M. Mitchell, M. A. Austin, Carl H. McCaskey, J. T. Oliphant, N. K. Forster, J. E. Ferrell, Floyd T. Romberger, Cleon A. Nafe, Augustus P. Hauss and C. S. Black; and ex-officio, the president, president-elect, executive secretary, and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 3:00 P.M., Monday, October 29, in the Auditorium, Athenaeum, and again at 11:30 A.M., Wednesday, October 31, in the Auditorium, Athenaeum. (Luncheon meeting.)

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Address of president-elect.
6. Report of executive secretary.
7. Report of the treasurer.
8. Report of the chairman of the Council.
9. Reports of councilors.
10. Reports of standing and special committees:
    - (1) Executive Committee.
    - (2) Constitution and By-Laws.
    - (3) Convention Arrangements.
    - (4) Industrial Health.
    - (5) Medical Education and Hospitals.
    - (6) Public Policy and Legislation.
    - (7) Public Relations.
    - (8) Sub-Committee on Physician-Patient Relations.
    - (9) Publicity.
    - (10) Rural Health.
    - (11) Scientific Exhibits.
    - (12) Scientific Work.
    - (13) Auditing.
    - (14) Cancer.
    - (15) Chronic Illness.
    - (16) Civil Defense.
    - (17) Conference of County Medical Society Officers.
    - (18) Crippled Children Services.
    - (19) Diabetes.
    - (20) Foot Hygiene.
    - (21) Hard of Hearing.
    - (22) Heart Disease.
    - (23) Indiana A.M.A. Campaign Coordinating Committee.
    - (24) Indiana Inter-Professional Health Council.
    - (25) Infantile Paralysis.
    - (26) Instructional Courses.
    - (27) Maternal and Child Health.
    - (28) Medical and Nursing School Scholarships.
    - (29) Mental Health.
    - (30) Military Manpower.
    - (31) Necrology.
    - (32) Physician-Hospital Relationship.
    - (33) Prepaid Medical and Hospital Insurance.
    - (34) School Health and Physical Education.
    - (35) State Fair.
    - (36) Traffic Safety.
    - (37) Tuberculosis.
    - (38) Venereal Disease.
    - (39) Veterans Affairs and Rehabilitation.
    - (40) Journal Publication.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1951, and their successors must be elected at the session: Delegates to the American Medical Association to succeed F. S. Crockett, Lafayette, and William M. Cockrum, Evansville; and alternates A. M. Mitchell, Terre Haute, and Cleon A. Nafe, Indianapolis.

Delegates from the second, fifth, eighth and eleventh districts are reminded that the terms of their councilors will expire December 31, 1951, and new councilors should be elected to succeed the following:

Second District: William C. Reed, Bloomington.
Fifth District: A. M. Mitchell, Terre Haute.
Eighth District: E. H. Clauser, Muncie.
Eleventh District: Elton R. Clarke, Kokomo.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

LUCILLE KRIBS,
Acting Executive Secretary.

Reports of Officers and Committees

EXECUTIVE SECRETARY

The state medical association is approaching another annual session with a record of another successful year. A review of the reports of the various committees will confirm this statement.

As far as the executive secretary is concerned, his greatest responsibility of the last twelve months was serving as a lobbyist for the association during the sixty-one day session of the Indiana General Assembly. Despite the fact that two physicians were members of the House of Representatives and one was in the Senate, constant vigil was necessary, and at times the going was rough and rugged. But if you will read the report of the Committee on Public Policy and Legislation to the delegates, you will note that medicine came through the session unscathed.

The past year was marked with exceptional activity upon the part of the committees, generally speaking. The postgraduate telephone seminars of the Committee on Medical Education and Hospitals won national recognition for Indiana, and the series of meetings the Committee on Rural Health held with county medical society officers was an innovation that proved to be very worthwhile. Mr. Waggener, the field secretary, worked with many of the committees and he shares in the success of their undertakings.

About 90 percent of the executive secretary's work is detail and routine. It might be said that he keeps the engine greased and keeps the ship on its true course. His foremost thought is how best to serve the wants of the members and to promote and protect their interests. In this connection the executive secretary is kept busy on a variety of duties, none of which makes glamorous reading.

As the executive secretary has often told his friends, he never had a job where he worked any harder or which he enjoyed any more.

The executive headquarters of the association is staffed with experienced and efficient personnel. If the executive secretary achieves any degree of success in his work, it is due largely to the help and cooperation of the staff.

RAY E. SMITH, *Executive Secretary.*

TREASURER

During 1950 investments in the Medical Defense Fund were increased by $3,000.00, $1,000.00 of which was realized from maturity of a $3,000.00 Baby Bond at $4,000.00 and investment of an additional $2,000.00 from the Medical Defense Fund checking account. The $3,000.00 was invested in United States Savings bonds, Series G.

The following is a detailed report prepared by George S. Olive and Company of Indianapolis, showing the financial status of the association as of December 31, 1950. The bank balances of the General Fund, Medical Defense Fund, THE JOURNAL Fund and Petty Cash Fund as of July 31, 1951, may be found in the report of the Auditing Committee.

January 11, 1951

The Council,
Indiana State Medical Association,
Indianapolis, Indiana

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1950, and the statements of income and expense, and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets, all funds, and related statements of income and expense, on the basis of cash received and disbursed, present fairly the position of the Indiana State Medical Association at December 31, 1950, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Yours very truly,
Geo. S. Olive Co.
Certified Public Accountants

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Increase in Assets, All Funds.

Year Ended December 31, 1950

TOTAL ASSETS, DECEMBER 31, 1950	**$75,298.29**
TOTAL ASSETS, DECEMBER 21, 1949	**72,678.56**
NET INCREASE	**$ 2,619.73**
Arising from the following sources:	
Excess of operating cash disbursements over operating cash receipts, general fund, year ended December 31, 1950:	
Receipts—	
Exhibit C	$129,562.82
Disbursements—	
Exhibit C	132,993.32
	$(3,430.50)
Excess of operating cash receipts over operating cash disbursements, The Journal of the Indiana State Medical Association, year ended December 31, 1950:	

Receipts—		
Exhibit D	39,316.67	
Disbursements—		
Exhibit D	35,632.42	
		3,684.25
Excess of operating cash receipts over operating cash disbursements, Medical Defense Fund, year ended December 31, 1950:		
Receipts—		
Exhibit E	4,642.75	
Disbursements—		
Exhibit E	5,276.77	
	(634.02)	
Add: Purchase of U. S. Savings bonds	2,000.00	
Increment from U. S. Baby bonds	1,000.00	
		2,365.98
NET INCREASE		$ 2,619.73

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION

Statement of Assets, All funds, at December 31, 1950

GENERAL FUND:			
Cash on deposit—Exhibit C		$ 5,533.51	
Petty cash fund		500.00	
Investments:			
Indianapolis City Hospital bonds	$ 4,000.00		
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	32,000.00		
		41,000.00	
Total general fund			$47,033.51
THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:			
Cash on deposit—Exhibit D			8,507.08
MEDICAL DEFENSE FUND:			
Cash on deposit—Exhibit E		1,757.70	
Investments:			
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	13,000.00		
		18,000.00	
Total Medical Defense Fund			19,757.70
TOTAL ASSETS, ALL FUNDS—Exhibit A			$75,298.29

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1950, and December 31, 1949

General Fund

	Year Ended December 31, 1950	December 31, 1949	Increase (Decrease)
CASH BALANCE AT BEGINNING OF YEAR	$ 8,964.01	$ 16,195.94	$(7,231.93)
RECEIPTS:			
Membership dues	117,682.50	53,300.00	64,382.50
Income from exhibits	7,938.50	15,080.00	(7,141.50)
Interest income	1,112.50	1,165.00	(52.50)
Postgraduate study fees	430.00	----------	430.00
Proceeds from matured bonds	1,000.00	----------	1,000.00
Krannert Nurse Scholarship fund	1,200.00	----------	1,200.00
Egbert Medical Scholarship fund	100.00	----------	100.00
Centennial book fund	63.30	357.20	(293.90)
Instructional courses	36.02	239.94	(203.92)
A. M. A. campaign fund	----------	17,000.00	(17,000.00)
Checks written off and miscellaneous refunds	----------	17.50	(17.50)
	129,562.82	87,159.64	42,403.18
BEGINNING BALANCE PLUS CASH RECEIPTS	138,526.83	103,355.58	35,171.25
DISBURSEMENTS:			
Transfer of applicable portion of dues to The Journal of the Indiana State Medical Association—Exhibit D	11,004.00	14,213.00	(3,209.00)
Medical Defense Fund—Exhibit E	4,327.75	2,691.00	1,636.75
Purchase of securities	1,000.00	----------	1,000.00
Headquarters' office expense	21,106.05	26,837.25	(5,731.20)
Publicity committee	730.37	1,068.44	(338.07)
Public policy	6,846.60	2,265.62	4,580.98
Council	1,105.31	1,076.55	28.76
Officers	2,897.51	3,538.79	(641.28)
Annual session	7,399.85	17,865.81	(10,465.96)
Miscellaneous committees	9,898.97	14,363.03	(4,464.06)
Federal insurance contributions tax	217.78	139.63	78.15
Indiana unemployment compensation and excise tax	435.58	483.38	(47.80)
Refunds of dues	38.00	----------	38.00
Refunds of exhibit rent	77.50	----------	77.50
Fifty-year Club	35.04	176.91	(141.87)
Increase in petty cash fund	----------	300.00	(300.00)
Woman's Auxiliary to I.S.M.A.	218.35	800.00	(581.65)
Indiana A.M.A. Campaign Coordinating Committee—	64,883.75	8,511.55	56,372.20
American Medical Association dues	612.50	----------	612.50
General practitioner award	58.10	60.61	(2.51)
Miscellaneous	100.31	----------	100.31
	132,993.32	94,391.57	38,601.75
CASH BALANCE AT END OF YEAR	$ 5,533.51	$ 8,964.01	$(3,430.50)

(Exhibit B)

Exhibit D

INDIANA STATE MEDICAL ASSOCIATION
Statement of Cash Receipts and Disbursements,
Year Ended December 31, 1950
The Journal of the Indiana State Medical Association

BALANCE, JANUARY 1, 1950		$ 4,822.83
RECEIPTS:		
Subscriptions—members—Exhibit C	$11,004.00	
Subscriptions—non-members	409.00	
Advertising	27,115.13	
Collections on accounts receivable	355.15	
Single copy sales	210.99	
Electrotypes	222.40	
Total receipts—Exhibit A		39,316.67
		44,139.50
DISBURSEMENTS:		
Salaries	7,400.00	
Printing	24,664.07	
Office postage	320.24	
Journal postage	624.19	
Advertising commissions	51.30	
Electrotypes	937.36	
Press clippings	50.75	
Editor and editorial board expense	291.56	
Office supplies	156.93	
Rent	480.00	
Electricity	22.08	
Telephone and telegraph	209.67	
Federal insurance contributions	106.52	
Indiana unemployment compensation and excise tax	213.00	
Miscellaneous	104.75	
Total disbursements—Exhibit A		35,632.42
BALANCE, DECEMBER 31, 1950—Exhibit B		$ 8,507.08

Exhibit E

INDIANA STATE MEDICAL ASSOCIATION
Statement of Cash Receipts and Disbursements,
Year Ended December 31, 1950
Medical Defense Fund

BALANCE, JANUARY 1, 1950		$ 2,391.72
RECEIPTS:		
Transfer of applicable portion of dues from the general fund—exhibit C	$ 4,327.75	
Interest income	315.00	
Total Receipts—exhibit A		4,642.75
		7,034.47
DISBURSEMENTS:		
Malpractice fees	1,476.77	
Attorney fees	1,800.00	
Purchase of U. S. Savings bonds	2,000.00	
Total disbursements—exhibit A		5,276.77
BALANCE, DECEMBER 31, 1950—exhibit B		$1,757.70

ROY V. MYERS, M.D., *Treasurer.*

CHAIRMAN OF THE COUNCIL

The Council has had an uneventful year, with national medical politics quiet. But the Council has plans ready for action if needed in the next national election. There is presently more concern about socialistic advances masquerading under various proposed schemes and ostensibly for health and medical education improvement.

Standards for income retirement plans have been worked out with great care by a Council committee and are available for adoption by such companies as may desire to use them.

The telephone seminar approach in postgraduate instruction has been received well and is to be continued under direction of the committee and the field secretary. It entails no cost to the Association and the participating members have an excellent hour's program for a few cents. Other states have become interested in our program and those responsible deserve much credit.

A special committee has labored diligently in setting up a state-wide County Health Council plan in which direction of the activities of these councils, if and when organized, will be directed and supervised by medical men. As substantial funds are required for such a plan the Council approved participation, but only if and when adequate funds are available from other sources.

The Council finds that it has authority in ethical breeches on appeals. The grievance committee may only suggest. In small societies there is disinclination to take action that at times seems necessary. Because of a recent case, not readily handled through existing agencies and yet doing substantial harm to the profession, the Council proposes an amendment to the Constitution giving it authority to take initial action if necessary. This does not disturb the regular chain of procedures which has long existed.

Because of a strike of personnel in one of our large hospitals, with the consequent serious dangers to the sick of that community, which were real and actual, the Council set up a committee to formulate a policy for the association in such matters, it being the view of the Council that nothing shall interfere with the care of the sick.

The plan of subsidizing education to secure more rural physicians has not worked well and the Council feels it should be revoked until a more practical method is devised.

The Council has been diligent in attempting to clarify the A.M.A. dues situation, which has not been sufficiently clear.

The usual changes in the Council membership have resulted in three new Councilors for next year. The loss of Dr. A. M. Mitchell from our body because of ill health removes one who has long served us faithfully and competently. The Council also notes the retirement of Dr. Clauser and Dr. Reed, both of whom have been outstanding in constant attendances and unselfish devotion to the welfare of the association.

The Council records its appreciation of the work of the Executive Committee, which, in its frequent meetings, has screened and analyzed the important matters for the final action of the Council.

The Council also requested the A.M.A. delegates to attend its sessions, that it may keep better informed, and the delegates kept advised of the association's wishes and policies.

And the Council expresses its appreciation of the cooperation of the various standing and special committees of the association, which have kept it constantly advised of their activities, and also its appreciation of the work of the Executive Secretary and the associated personnel.

W. U. KENNEDY, M.D., *Chairman.*

REPORTS FROM DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

The First District has continued its activity in the campaign against Socialized Medicine. The American Way, Inc., in Evansville, has been a great help.

The new hospital near Tell City has been completed and is serving that area.

There has been some trouble in Evansville between certain hospitals and doctors over classification and limitation of work by these hospitals.

There is to be a new St. Mary's Hospital here in the near future. The site has been purchased and funds have been secured.

HERMAN T. COMBS, M.D., *Councilor.*

SECOND COUNCILOR DISTRICT

During the past year no serious problems have arisen in the Second District. The Freeman-Greene Hospital at Linton is being extensively remodeled and Vincennes is enjoying a new modern hospital.

At the annual district meeting held in Washington May 24, Dr. Arthur G. Blazey of Washington was elected councilor and will take office the first of the year. Dr. J. S. Brown of Carlisle was re-elected secretary. Linton was named as the meeting place for 1952 with Green County as the host society.

Dr. C. Basil Fausset of Indianapolis gave a paper on "Psychosomatic Surgery" and Dr. H. D. Junkin of Paris, Illinois, discussed "Skeleton Pinning and External Fixation of Fractures." Both papers were well received and thoroughly discussed.

Speakers at the dinner were Dr. Alfred Ellison of South Bend, president of the state association, and Dr. Lester D. Bibler of Indianapolis, who spoke on "The Hospital and the General Practitioner." Dr. C. Philip Fox of Washington, district president, presided.

An interesting feature of the meeting was the presence of the Woman's Auxiliary. The ladies met during the afternoon for a business meeting and joined the doctors at the Elk's Club in the evening for dinner.

WILLIAM C. REED, M.D., *Councilor.*

THIRD COUNCILOR DISTRICT

The Third District meeting was held in New Albany. It was well attended and a splendid program was presented. We were fortunate in having as one of our speakers the president of our association.

The Third District has two new hospitals, opened within the last year: one at Salem and one at Corydon. Ground was broken in July at New Albany for the Floyd County Memorial Hospital. We expect it to be opened for use late in 1952. These new hospitals will relieve our critical hospital bed shortage.

The theme in our district is to practice medicine and surgery so that the doctors following us may enjoy the same honored heritage we received from our predecessors.

WM. H. GARNER, M.D., *Councilor.*

FOURTH COUNCILOR DISTRICT

The Fourth District Medical Assembly met at North Vernon, May 16 with about seventy members present. At the delegates meeting the following officers were elected for next year's meeting, to be held at Madison:

President, Dr. Luther Beetem, Madison
Vice-President, Dr. George Macy, Columbus
Secretary and Treasurer, Dr. Robert O. Zink, Madison
Alternate Councilor, Dr. George Row, Osgood

The scientific session in the afternoon was devoted to a symposium on chest diseases and treatment of the same. This discussion was directed by Drs. James Battersby and R. M. Vandivier.

CHARLES OVERPECK, M.D., *Councilor.*

FIFTH COUNCILOR DISTRICT

All the societies in the district are functioning and in good condition.

Dr. M. C. Topping of Terre Haute was elected councilor from the fifth district to replace Dr. A. M. Mitchell, who requested he be relieved of his duties due to his health. Doctor Mitchell had served as councilor since 1942, in addition to many other duties in association affairs.

Dr. Gilbert D. Rhea, Greencastle, was elected president; Dr. Opal L. Wood, Brazil, was elected vice-president and Dr. S. R. Combs, Terre Haute was re-elected secretary-treasurer. The 1952 meet-

ing is to be held on the second Wednesday in May at the Old Trails Inn, near Greencastle.

Fifty-three members of the district attended the scientific meetings, held in the Phoenix Country Club in the afternoon. Dr. J. Stanley Battersby, Indianapolis, gave a paper on "Surgical Conditions of Diseases of the Chest." Dr. Robert J. Rohn, Indianapolis, discussed "The Recognition and Management of the Hemorrhagic Disorders," and Dr. Paul Merrell, Indianapolis, presented a paper on "Herniated Nucleus Pulposus, Cervical and Lumbar."

The program closed with a dinner followed by a few remarks by Dr. Alfred Ellison, president of the Indiana State Medical Association, who discussed the activities of the association. Richard Mills of Indianapolis closed the meeting with a humorous lecture.

Ray E. Smith and James Waggener attended and gave short talks.

A. M. Mitchell, M.D., *Councilor.*

SIXTH COUNCILOR DISTRICT

A quiet year has followed our very considerable and successful activity in political matters last year.

The annual district meeting at Liberty, with a program of interest and merit, was very well attended. The Society changed its rules to provide for the annual election of officers. The next meeting will be at Rushville at such date as will permit attendance by the state officers. This meeting was saddened by the serious illness of its retiring president, Dr. Will Thompson, who has worked in it so long and faithfully. Dr. F. B. Mountain of Connersville was elected president, Dr. Harry Ross of Richmond as vice-president, and Dr. R. W. Kuhn of Wilkinson was re-elected as secretary, a post he has competently filled for many years.

Growth of hospital facilities has been considerable. Every county but one has a new hospital or has additions to the present ones, in building or authorized.

The telephone seminars have been well received and well attended.

Age, illness, and death have removed a number of our veterans, who have been with and for us over many years. The District has had several additions to our forces and there is no shortage of medical care though the military service has temporarily lost us the services of a few younger men.

Public relations have been well maintained, with well planned setups for emergency and round-the-clock service, principally based on our hospitals, and doctors in each county have participated in all the health movements and fund campaigns.

There are no pressing problems and no controversies existing, but an organizational setup remains for immediate use in political matters involving our professional beliefs.

W. U. Kennedy, M.D., *Councilor.*

SEVENTH COUNCILOR DISTRICT

The Seventh District Medical Society held its annual meeting in Pittsboro, on October 18 last year. Dr. E. M. Pitkin, of Martinsville, assumed the presidency. Dr. William Province, of Franklin, was elected president-elect. Dr. Ralph V. Everly, of Indianapolis, was re-elected secretary-treasurer. Dr. Roy A. Geider, of Indianapolis, was re-elected councilor of the district. The meeting was attended by sixty-five members and their wives. Members of the Woman's Auxiliary were entertained at a doll style show in the afternoon. In the evening both members and their wives enjoyed an excellent chicken dinner. Following the dinner, a movie and a talk on Americanism were presented by the Indianapolis Chamber of Commerce.

At the Indianapolis meeting, held April 8, 1951, at the Methodist Hospital, Dr. E. M. Pitkin, of Martinsville, presided. The program was conducted by the Indianapolis Man-Power Committee and Dr. John Owens, chairman of the state Man-Power Committee. A pleasant surprise was the personal appearance of General Armstrong, Surgeon-General of the Army, who discussed the problems of the Medical Corps during the present emergency.

As this report is being written, word has just been received of the death of our friend and executive secretary, Ray E. Smith. It would be amiss not to acknowledge our deep grief and keen sense of loss at the passing from our society of such a devoted worker and esteemed friend.

Roy A. Geider, M.D., *Councilor.*

EIGHTH COUNCILOR DISTRICT

The Eighth District Society held its annual meeting at Portland on May 23, 1951, with the Jay County Society as host.

Program consisted of a golf tournament, business and scientific sessions. President-elect Dr. J. W. Wright and James Waggener were special guests.

Dr. Donald B. Effler from the Cleveland Clinic presented a most excellent review of the subject "Bronchogenic Carcinoma."

A resolution was adopted changing the By-laws, limiting the term of office of councilor to two terms.

Officers elected for 1952 are: Dr. Gordon Wilder, president, Dr. Warren Fisher, secretary-treasurer, and Dr. Forrest E. Keeling, councilor.

Lack of hospital facilities continues to be a major problem in this area. Randolph and Jay counties have made substantial progress in meeting this need.

The first annual meeting of the District's Auxiliary was held in conjunction with the Portland meeting.

E. H. Clauser, M.D., *Councilor.*

NINTH COUNCILOR DISTRICT

At the meeting of the Ninth Councilor District at the Lafayette Country Club on May 24, 1951, Crawfordsville was designated as the host for the 1952 meeting.

There was a full day of activity for the 149 members who were in attendance at Lafayette. A golf tournament was held in the morning and the afternoon meetings were devoted to the scientific program. During the afternoon session there were excellent papers by Drs. Martin L. Harshman, Roland E. Miller, Robert W. Vermilya, William B. Ferguson and Ramon B. Dubois. Following the scientific meeting, a meeting of the delegates was held. Dr. Roland E. Miller of Lafayette presided at the meeting and Dr. Hugh B. McAdams of Lafayette was secretary.

During the afternoon the auxiliary was honored by the presence of Mrs. F. M. Fargher of Michigan City, president of the Woman's Auxiliary of the Indiana State Medical Association. Officers for the auxiliary were elected for the coming year as follows: president, Mrs. N. F. Peacock of Crawfordsville; vice-president, Mrs. Boyd Burkhardt of Tipton; secretary, Mrs. Richard E. Hughes of Lafayette.

At the evening meeting we were honored by the presence of Dr. J. William Wright of Indianapolis, president-elect of the Indiana State Medical Association. The principal address was given by George D. Scarseth, Ph.D., Lafayette, director of research, American Farm Research Association, and research consultant, Standard Fruit and Steamship Company. His broad experience and world-wide travels, coupled with his keen sense of humor, made his address entitled "Soil, Civilization and Our Health" extremely interesting. We were also honored, during the delegates' meeting and the banquet, by the presence of Dr. Claude S. Black of Warren, past president of the Indiana State Medical Association.

The Ninth District can report a year of progress and of increased activity of the county societies in this district in public relations. The various societies report active participation in efforts of the Indiana State Medical Association and American Medical Association to combat federal control of medical practice. Mrs. Cecil Harden, Representative from the Sixth Congressional District, has been most helpful in seeking the views of the medical profession in legislative matters and many members in the district have kept closely in touch with her.

Several of the smaller societies have difficulty in maintaining regular meetings but the larger societies in the district are active and maintain regular meetings and scientific discussions. Special efforts have been made to provide "round-the-clock" medical service and several of the societies have very active public relations committees which have been helpful in obtaining speakers for various civic organizations. It is satisfying to note that many of the physicians are particularly active in the work of the County Health Councils.

WEMPLE DODDS, M.D., *Councilor.*

TENTH COUNCILOR DISTRICT

Defense against atomic disaster has been the key effort in the Tenth Councilor District this year. Acutely conscious of the prominence of the industrial targets in the northwest corner of the state, the Tenth District's fall meeting was almost entirely devoted to the subject of Civil Defense.

A three hour afternoon program of Army films covered the subject from medical, military and civilian angles. A dinner was held at Phil Smidt's restaurant in Whiting with a group of 250 present. Agreeing that the Tenth District and the city of Chicago must work their plans out for civilian defense together, Dr. Andrew C. Ivy, vice president of the University of Illinois, and chairman of Chicago's Civil Defense committee, led off with a detailed two hour explanation of the "Chicago Plan."

Much of this plan has now become a reality in the district. First aid classes are being held throughout the district. Blood typing and tagging have been virtually completed in Porter County. Lake County is pioneering for the nation a "Tat-Typing" program of blood typing (blood group and Rh factor) on plastic identification cards and tattooing the symbols electrically on the body. This is being done on the Tuberculosis Association's mobile x-ray unit at a cost of fifty cents, paid by the individual typed. In a period of three months, nearly 10,000 have been completed.

With the help of the Boy Scouts, a copy of the I.S.M.A.—Blue Shield pamphlet, "Survival Under Atomic Attack" is being put in every mail box in Lake County. The Medical Society has shown films and given talks on its plans to nearly seventy-five lay organizations.

At the October meeting Dr. William H. Howard of Hammond was re-elected councilor for three years. Dr. Frank G. Sink of Remington was named president, and Dr. H. E. English of Rensselaer, secretary.

The April meeting was again held at Phil Smidt's, and included an afternoon tour of the American Maize Company's plant. In the evening Dr. Carlo Scuderi, University of Illinois, discussed "Bone Surgery for Massive Long Bone Defects," and Dr. Edward Holmblad, General Manager of the American Association of Industrial Physicians and Surgeons, spoke on "Doctor-Patient Relationships."

WILLIAM H. HOWARD, M.D., *Councilor.*

ELEVENTH COUNCILOR DISTRICT

The past year has been a busy one for us in the Eleventh District. Our fall meeting of 1950 was held at the Hotel LaFontaine at Huntington with papers by R. Morton Bolman, M.D., of Ft. Wayne on "Vagotomy in Treatment of Peptic Ulcer," Richard S. Griffith, M.D., of the Eli Lilly Research Department on "Hypertension," and an animated cartoon picture on "Psychiatry" by Harry S. Dunstone, M.D., of Ft. Wayne.

The spring meeting was held at the Mississinewa Country Club just east of Peru, where Dr. R. Gordon Brown gave a talk on "The Medical Aspects of Atomic Energy," using much illustrative material such as charts, Geiger counters and other scientific apparatus. Election held at this meeting resulted in selection of Dr. O. G. Brubaker of North Manchester for president, and re-election of Dr. C. R. Herd of Peru for secretary-treasurer, Dr. E. R. Clarke of Kokomo as councilor, and Dr. E. B. Jewell of Logansport as necrologist.

Detailed reports by counties, as far as I have been able to compile them, are as follows:

CARROLL. Now has 10 active members and 1 senior member. Has gained two new members, both in Delphi—Dr. John M. Byrne and Dr. John M. Wagoner.

Dr. Charles C. Crampton of Delphi, Indiana's General Practitioner of the Year for 1949, was presented with the Distinguished Alumni Award at the 77th anniversary of Founder's Day at Purdue University.

Dr. Thomas Brown of Delphi was appointed City Health Officer for a four year term, and Dr. George Wagner was appointed to a two year term as a member of the City Health Board.

Two members died in the past year: Dr. Herbert Y. Mullin, 73, of Rockfield, July 20, 1950, and Dr. Hubert Gros, 47, of Delphi, March 31, 1951.

The society is doing preschool examinations, and is active in the school immunization program.

CASS. Now has 27 active, 4 senior members. Two members died, Dr. Russell R. Rollins, 56, of Royal Center, March 31, 1951, and Dr. Warren R. Hickman, 45, of Logansport, January 29, 1951.

Residents of Walton honored Dr. E. P. Flanagan with a "Doc Flanagan Day," July 30, 1950.

Dr. John Larson at the Logansport State Hospital announced the appointment of two new staff members: Dr. George W. Morrow, assistant superintendent, formerly at Kankakee, Illinois, and Dr. Max Pfuetze, resident physician and surgeon, formerly from Bakersfield, California.

GRANT. Now has 49 active, 4 senior members.

Four new members were added during the year, all at Marion: Dr. Henry H. Alderfer, Dr. W. J. Comeau, Jr. (Marion General Hospital), Dr. Forrest Leiter and Dr. Alvin Wiersma.

Three members have been lost by removal, Drs. Fred Dick, Jr., A. A. Sullenger and Clifford L. Williams, and one by death, Dr. Glen D. Kimball, 80, of Marion, September 28, 1950.

Dr. W. W. Ayers was honored by election as president of the Marion Rotary Club.

Dr. S. T. Ginsberg of the Veterans' Hospital was made an examiner for the American Board of Psychiatry.

Dr. Richard Davis has completed a fellowship in surgery and has come back to Marion to join his father and brother in the general practice of surgery.

Dr. Joseph B. Davis recently passed the American Board of Surgery examinations. He was appointed consultant in surgery at the Veterans' Administration Hospital in Marion.

Dr. Merrell S. Davis was recently appointed a member of the Board of Trustees of Indiana University by Governor Schricker and was also appointed to head a 5-member committee to study means of increasing number of physicians graduated at I.U. School of Medicine.

The society has under consideration sponsoring a professor of neuropsychiatry in one of the Japanese war-torn areas.

They are participating in the Cancer, Tuberculosis, Heart Disease and other health agency campaigns, and also in the Civilian Defense Program.

I have attended two outstanding meetings of the Grant County Society. They are getting timely and interesting programs and, as always goes with it, membership interest and attendance.

HOWARD. Active members, 42; senior members, 1.

New members, all in Kokomo, are all in limited fields of practice: Dr. John W. Alward, surgery (took examinations in March for American Board of Surgery), Dr. Max M. Earl, internal medicine, Dr. T. R. Crawford, internal medicine, Dr. Guy Morford, anesthesiology, and Dr. Max W. Rudicel, pathology.

One member, Dr. F. N. Murray, moved to the vicinity of Louisville, Kentucky, and one member died, Dr. W. H. Harrison, 86, of Kokomo, October 23, 1950.

Dr. C. C. Bowers was elected president of the Kokomo Lions Club, and Dr. E. R. Clarke, commander of the Kokomo Post No. 6 of the American Legion.

Dr. H. M. Rhorer is a member of the Board of Trustees of DePauw University.

Preliminary plans are being made to cooperate with surrounding county societies to provide assistance in case of bombing or other disasters.

HUNTINGTON. 23 active members, 1 senior.

One member died, Dr. G. G. Wimmer, 75, of Mt. Etna, October 13, 1950.

The society has worked out a disaster plan to be carried out in case of emergency.

MIAMI. 19 active members, 3 senior members.

One new member, Dr. Owen B. Johnson of Peru.

One became inactive, Dr. D. C. Ridenour of Peru.

One member died, Dr. Otho R. Lynch, 70, Dec. 25, 1950.

Officers of the Board of Health are: president Dr. C. R. Herd, secretary Dr. J. Yarling, and vice-president Dr. J. B. Berkebile.

School immunization has been one activity of the society.

I attended one meeting of this society in April, when there had been some trouble with hospital administration.

WABASH. Active members, 20; senior members, 3.

Society is meeting regularly. Specific details and news notes are lacking.

As I write this, we are all saddened by the report of the sudden death of our beloved Ray Smith, executive secretary of the Indiana State Medical Association. Ray has been our mainstay in organizational work and activities, and we shall miss him greatly. We in the Eleventh District felt especially close to Ray, as it was here in Kokomo that he was married, and our sympathy goes out to Mrs. Smith in her great loss.

E. R. CLARKE, M.D., *Councilor.*

TWELFTH COUNCILOR DISTRICT

The component societies of the Twelfth Councilor District are continuing to carry on for preventive as well as curative medicine.

We are getting more hospital beds and hospital equipment. The Methodist Hospital had a groundbreaking ceremony in Fort Wayne on August 12, 1951, for the new Parkview Memorial Hospital. This new hospital will be able to care for two hundred and sixty patients and will cost over three million dollars. We also have new modern hospitals in Whitley and LaGrange counties. Angola is having an addition to the Dr. Cameron Hospital. The Fort Wayne Veterans Hospital has a capacity of two hundred patients. This hospital has been in operation less than two years. Some of the other hospitals are planning to enlarge.

The Woman's Auxiliary met at Wolf & Dessauer's Department Store and the members of the Twelfth District Medical Society met at the Chamber of Commerce Building in Fort Wayne on May 17, 1951.

The Doctors and Woman's Auxiliary are planning to attend the Indiana State Medical meeting at Indianapolis.

M. B. CATLETT, M.D., *Councilor.*

THIRTEENTH COUNCILOR DISTRICT

The county societies comprising the 13th district of the state medical association have been active in improving public relations, emergency service, and generally improving the medical service to the people of this area. There have been a number of physicians who have entered the military service but this so far has not caused any acute shortage of doctors. The doctors throughout the district have been helping to guide the various lay health groups such as the cancer society, tuberculosis league, mental health, and children's health organizations. Several of our county societies have been meeting regularly with local departments of public welfare and have helped correct misunderstandings as to medical practice and charges but in one county there are some difficulties yet to be corrected. These meetings have been beneficial to the doctors as well as to the agency members and in some instances has resulted in raising the fees toward a more equitable level as compared to other welfare services.

The public relations committee of the St. Joseph County has done an excellent job of improving our relationship with union members by meeting once a month with the union insurance committee. The local union on one occasion has supported our views in regard to a legislative bill that would lower the standards of medical care. These meetings have created a feeling of friendliness between the two groups and a better understanding of the medical profession's aims and ethics.

The doctors and auxiliary members of the 13th district are to be commended for their very active work the past year in pointing out the dangers of socialized medicine during the election last November.

The annual meeting of the 13th medical district was held November 8, 1950, at Michigan City at which time an excellent program was arranged. In the morning a movie on obstetrics and surgery was presented first, followed by a clinico-pathological conference on potassium balance given by members of the South Bend Medical Foundation. Following the luncheon an excellent talk was given by Dr. Alfred Ellison, president of the Indiana State Medical Association in regard to the responsibility of the medical profession to the public. Following this a business meeting was held and the following officers were elected:

President 1951—Milo G. Meyer, M.D., Michigan City

Vice president 1951—Floyd S. Martin, M.D., Goshen

Secretary-treasurer 1951—O. E. Wilson, M.D., Elkhart

Councilor—Kenneth L. Olson, M.D., South Bend

Alternate councilor—G. O. Larson, M.D., LaPorte.

The outgoing officers: Dr. Howe, president; Dr. Stiver, vice president; and Dr. Wilson, secretary-treasurer, are to be commended for the excellent work they did during the preceding year.

The afternoon scientific program consisted of the following:

1. ACTH and Cortisone in Treatment of Arthritis, Edward F. Rosenberg, M.D., Chicago
2. Allergy Therapy—Recent Progress and Role of General Practitioner, Samuel W. Feinberg, M.D., Chicago
3. Banthine and the Ulcer Problem, Keith S. Grimson, M.D., Duke University

In the evening a dinner was given and the president, Dr. Ellison, and president-elect, Dr. Wright, were present, as well as Dr. Nafe and Mr. Ray Smith. Short talks were given by these men as well as Mr. Crumpacker, our newly elected congressman, who expressed his appreciation for the support given him by the doctors in his district and re-affirmed his stand against socialized medicine.

The speaker of the evening was Carl F. Steinhoff, M.D., Brigadier General of the Reserves from Chicago, and his subject was, "The Doctor's Role in Civilian Atomic Defense."

The auxiliary of the 13th district medical society held a meeting in the afternoon and met with us in the evening.

KENNETH L. OLSON, M.D., *Councilor.*

EXECUTIVE COMMITTEE

The Executive Committee is composed of the President, the President-elect, the Treasurer, Chairman of the Council and two members elected by the Council. It acts in behalf of the Council when the Council is not in session, and also serves as the Medical Defense Committee and the Budget Committee.

Between August 1, 1950, and August 1, 1951, the Executive Committee met ten times, once in its role as Budget Committee to prepare the 1951 budget of the association. At another meeting the committee devoted a majority of its time in conference with leaders of the state Woman's Auxiliary, for the Executive Committee is advisory committee to the auxiliary.

Meeting as it does nearly every month, the Executive Committee handles a large volume of the association's business. It has leaned over backward to keep from making decisions which could wait until the Council meets, and many matters were referred to the Council with or without recommendation.

It would be a duplication to place actions of the Executive Committee in this report, for minutes of all of the committee's meetings have appeared in THE JOURNAL and a copy of these minutes will be supplied each reference committee member.

THE JOURNAL

Getting out an issue of THE JOURNAL every month is routine work, but it embraces a tremendous lot of detail. Two full-time employees are necessary to handle the large volume of work.

Since August 1, 1950, five special issues have come off the presses. In August, 1950, the regular General Practice Number was published, followed the next month by the Convention Number. The April, 1951, issue was devoted to cancer. Something new in the way of special issues was the Civil Defense Number of June, 1951. It is believed to be the first issue of its kind. The regular Medical Yearbook issue, containing the roster of association members and information of medico-legal or medico-economic nature, appeared in July. Again, in August, 1951, was the General Practice Number.

Advertising

Advertising for the first six months of 1951 is more than $500 over the first six months of last year. This brightens the economic picture, and indicates a very successful 1951 as far as income is concerned. Printing costs have not risen in the interim, so THE JOURNAL's finances should be in healthy condition when the books are closed on December 31, 1951.

Figures on advertising for the first six months of the last three years, compared to the first six months of 1951, follow:

First Six Months	1948	1949	1950	1951
From A.M.A. agency	$ 8,743.76	$ 8,133.26	$ 7,836.86	$ 9,070.88
Direct to Journal	5,066.43	4,564.23	4,467.31	3,813.82
Total	$13,810.19	$12,697.49	$12,304.17	$12,884.70

PRINTING COSTS

THE JOURNAL printing costs have dipped since a new contract was negotiated with C. E. Pauley & Company in 1950. The costs, of course, are in direct ratio to the number of pages. The following table covers the last five-year period:

Year	Cost	Number of Pages (Inserts Excluded)
1946	$21,283.49	1,476
1947	$24,790.34	1,462
1948	$26,391.00	1,380
1949	$28,572.41	1,360
1950	$24,664.07	1,324
1951 (six months)	$10,325.36	564

The following table shows the number of Journal pages for the past six years:

Year	Reading	Per Cent Reading	Adv. Pages	Per Cent Adv.	Total Pages	Avg. Pages Per Issue
1945	580	44	754	56	1334	111.1
1946	696	46	824	54	1520	126.7
1947	681	45	837	55	1518	126.5
1948	703	49	707	51	1410	117.5
1949	740	53	652	47	1546*	262.0
1950	690	51	664	49	1354	112.8

*Includes 172 pages of "One Hundred Years of Indiana Medicine."

The Executive Committee has changed the title of the executive secretary from managing editor of THE JOURNAL to businesss manager. This change recommended itself since the executive secretary is concerned with the business operation of the magazine, and the editorial policies and contents come within the jurisdiction of the editor and the Editorial Board.

MEDICAL DEFENSE ACTIVITIES

1. *Malpractice cases.* A year ago, at the time of this report, August 1, 1950, the following ten cases were pending before the committee, one of which was closed during the year, leaving nine cases still pending:

Case No. 200—Filed February 12, 1932. Pending.

Case No. 249—(Closed). Filed January 6, 1944. Case dismissed because of death of defendant. Expense, $525.00, paid June 6, 1951.

Case No. 251—Filed September 25, 1942, Pending.

Case No. 255—Filed September, 1945. Awaiting assignment for trial.

Case No. 268—Filed September 7, 1948. Pending.

Case No. 269—Filed September 28, 1949. Pending.

Case No. 270—Filed September 28, 1949. Pending.

Case No. 271—Filed September 16, 1949. Pending on change of venue.

Case No. 272—Filed December 27, 1949. Pending.

Case No. 273—Suit not yet filed. Effort being made to obtain settlement.

Since August 1, 1950, and up to August 1, 1951, the following three new cases have come before the committee, making a total of twelve cases pending at the present time as against ten unclosed cases at the same time last year:

Case No. 274—Filed May 25, 1951. Pending.

Case No. 275—Filed September, 1950. Pending.

Case No. 276—Filed April 11, 1951. Pending.

The following case was closed prior to August 1, 1951, but as statement for attorney's fee was received and paid *after* that date, this case is listed again this year:

Case No. 252—(Closed). Filed August, 1944. Dismissed for lack of prosecution, July 1950. Expense, $518.54, paid September 8, 1950.

2. *Medical Defense Fund Statment, from August 1, 1950, to August 1, 1951:*

Balance, August 1, 1950 ---------- $4,697.49

Receipts:

Dues, 85—1950 members	$ 106.25	
3,303—1951 members	4,128.75	
Interest on bonds	460.01	4,695.01
		$9,392.50

Disbursements:

Malpractice fees	$1,043.54
Salary of Association attorney	1,800.00
Purchase of U. S. Savings Bonds	2,000.00
	$4,843.54
Balance in Medical Defense Fund checking account, August 1, 1951	$4,548.96

W. L. PORTTEUS, M.D., *Chairman*
C. J. CLARK, M.D.
ALFRED ELLISON, M.D.
J. WILLIAM WRIGHT, M.D.
W. U. KENNEDY, M.D.
ROY V. MYERS, M.D.

COMMITTEE ON CONSTITUTION AND BY-LAWS

As there has been no business for the Committee on Constitution and By-laws, we have no report to make at this time.

GEORGE A. MAY, M.D., *Chairman*,
I. E. HUCKLEBERRY, M.D.,
ROBERT G. MOORE, M.D.,
SAMUEL T. MILLER, M.D.,
THOMAS M. CONLEY, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health for the year of 1951 has had one chief project which is the "Medical Direction for the Nurse in Industry." This project is now completed. We have spent a great deal of time on this and I think it is a very excellent piece of work. At first we thought this would be a simple project but after getting into it our committee found it would take a great deal of hard work and time to complete these orders. It has taken four or five years finally to get something that is worthwhile.

The subcommittee, which consists of Dr. Emmett Lamb, Chairman, Dr. Allan Harcourt and Dr. Louis Spolyar, has done a very excellent job. After getting the orders roughly prepared, we sent them to about 100 different industrial surgeons over the United States, asking them to check them over and give us their ideas and suggestions. We also sent a copy to the nurses' association and asked them to check it over and send a representative to discuss it with our committee.

We then had a committee meeting. The members of the industrial committee, some members of the executive committee of the state association and representatives from the Section on Industrial Nursing of the Indiana State Nurses' Association were present. The discussion was excellent. The representatives from the nurses' association gave some excellent suggestions which were incorporated in the revised orders. The orders have been revised

several times incorporating suggestions from various industrial doctors who replied to the first set of orders which we sent to them. We believe now that we have a set of orders which will stand up and meet practically all tests. Of course, we appreciate that it is impossible to have a *complete* set of orders.

We hope to have this ready to send out to the entire membership in the not too distant future. We hope that the state association will see fit to have this published in book form and submit it to all doctors, as well as to all of the plants in the state of Indiana so they may be guided by it.

The other activity which we have sponsored is the industrial meetings in various districts of the state. We have suggested that the meetings be held in a plant when possible; otherwise that medical industrial meetings be held on a county or district level. These have proved to be very interesting and very educational from the standpoint of a nonindustrial as well as an industrial doctor. Our program at these meetings is geared to take care of the general practitioner and the fellow who is doing most of the industrial work. Only about 5 percent to 10 percent of the industrial work in the state of Indiana is done by full-time men. We have tried to present material to those doctors who do most of the industrial work but do not specialize in it. The program of industrial education seems to be working very nicely in our medical school. We appreciate very much the cooperation of Doctor VanNuys and the trustees of the University in permitting these courses to be given. We think it has done a great deal of good. We would be very happy if even more courses could be given on industrial health and medicine. We think they tie in closely with public health.

Again I want to compliment the chairman and the committee who have worked so hard on these standing orders for industrial nurses. I don't think too much praise can be given for the vast amount of time that has been spent on this in the past year. I believe they have done an excellent job.

I also want to thank the rest of the committee for the fine work they have done.

E. S. Jones, M.D., *Chairman*
L. S. McKeeman, M.D.
Richard S. Swan, M.D.
John W. Hilbert, M.D.
Louis W. Spolyar, M.D.
William L. Daves, M.D.
Edward H. Carleton, M.D.
Emmett B. Lamb, M.D.
Allan K. Harcourt, M.D.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Your committee on Medical Education and Hospitals has concerned itself primarily during the past year with developing a means of supplying postgraduate education to many of our societies throughout the state.

Following many discussions by the committee it was deemed advisable to try furnishing postgraduate education programs by long distance telephone. The staff of St. Elizabeth Hospital in Lafayette was cooperative in acting as a test center for this system, underwriting the cost of the program in order that the committee might test the effectiveness of this type of presentation.

Your committee then met with the postgraduate committee of the Medical School and discussed the possibility of supplying a program by this method to St. Elizabeth Hospital Staff and, if successful, to project the method to other county societies throughout the state. Accordingly, the test program was given on October 3, 1950. One hundred seven physicians were in attendance at Lafayette and practically 100 percent returned the questionnaire following the program. The favorable comments received induced the committee to announce this method of postgraduate education as being available to all county societies who might desire to participate.

Beginning in November 1950, the programs were carried on for a period of seven months, with one program being given each month. The programs continued to be accepted by more county societies during each month of their operation. It is the opinion of the committee that its activity in this endeavor should be reported in detail for your information as follows:

November 7, 1950
- Participating Societies 13
- Potential listening audience 534
- Program subject: Therapeutics Round Table

December 5, 1950
- Participating societies 21
- Potential listening audience 663
- Program subject: Chemotherapy in Urinary Tract Infections

January 2, 1951
- Participating societies 25
- Potential listening audience 688
- Program subject: Carcinoma of the Cervix

February 6, 1951
- Participating societies 28
- Potential listening audience 802
- Program subject: Some Aspects of Cardiovascular Diseases

March 6, 1951
- Participating societies 28
- Potential listening audience 802
- Program subject: Symposium on Nonmalignant Diseases of the Bowel

April 3, 1951

Participating societies 31
Potential listening audience 1201
Program subject: Cancer Round Table

May 1, 1951

Participating societies 29
Potential listening audience 884
Program subject: The Acute Abdomen

One of the unusual programs of the series was given on February 6. For this program arrangements were made for Dr. H. B. Sprague and Dr. S. A. Levine, of the Harvard Medical School faculty, and Dr. Arlie R. Barnes and Dr. Edgar B. Allen of the Mayo Clinic, to participate in the program. Drs. Sprague and Levine talked from their offices in Brookline, Massachusetts; Drs. Barnes and Allen talked from their offices in Rochester, Minnesota; while Dr. George S. Bond, moderator of the program, spoke from the auditorium of the Indiana University School of Medicine. This test proved the possibility of reaching out into any section of the country to bring to Indiana physicians outstanding men in fields of medicine.

On the basis of the above report, the committee is able to report an average of 25 societies participating in each of the seven programs, with an average potential listening audience of 799 plus. This we believe establishes a new record for postgraduate participation in our state.

These programs were offered to the societies for 50c per active society member, per hour, with a minimum charge of $10 and a maximum charge of $30 per program being made to the societies. In addition to the money paid in by the participating societies, your committee received the following gifts: $423.66 from the Indiana Heart Foundation; $200 from the Indiana Cancer Society. This money was paid to offset the additional expense of offering the February and April programs.

Your committee found it necessary to purchase a wire recorder and to make recordings of these programs for use by some of those societies not able to meet on the evening of the symposiums.

The following is a statement of our finances during the year:

Cash received, November 1950 to July 1, 1951		$2,455.00
Disbursements		
Telephone tolls, office	$ 74.75	
Printing	231.92	
Committee meetings	88.22	
Postage	79.40	
Recording Machine & Supplies	233.95	
Office Supplies & Miscellaneous	35.70	
Indiana Bell Telephone tolls, and engineering	1,288.56	2,152.50
Balance		$ 302.50

This program has been entirely self-supporting and it is the unanimous feeling of the committee that this program should continue to be self-supporting.

Following the close of the series a questionnaire was sent to each of the participating societies. The response was favorable and a new series was begun the first of October of this year and will continue throughout the winter and spring months.

Perhaps the most important fact concerning these symposiums is the opportunity it affords many of our county societies to have top-notch postgraduate programs, which in the past have not been able to afford such courses. The enthusiasm expressed by those listening to the programs, for the forward step which has been made by the association in recognizing this need, has been most gratifying. Physicians have been generous with their opinion that this type program, while it is not the complete answer to postgraduate education, is most acceptable, and provides an answer to an important need in the practice of modern medicine. Many societies report their attendance has increased because of these programs.

National attention has been focused upon our association for this activity. Requests have been received from every section of the country, seeking information on how this plan is being operated.

It is the desire of your committee at this time to acknowledge its appreciation to the participating societies and their members for their willingness to give this type of program a thorough test and for the sincerity of their suggestions which are proving so helpful in constantly improving this method of education.

Medical Education Foundation

Recognizing the principle of medical teaching in the voluntary efforts of a group of individuals, headed by former President Herbert Hoover, in organizing the National Medical Education Foundation, the A.M.A. likewise organized a similar program. By action of the House of Delegates at the Cleveland meeting, approval was given for the establishment of the A.M.A. Medical Education Fund, and one half million dollars was appropriated to get the fund started. It is the hope of the A.M.A. that individual physicians will give generously along with business and industry in raising sufficient funds to save our schools the necessity of accepting federal subsidies, and the accompanying controls, in order to meet operating deficits.

Organized on a voluntary, nonprofit basis the National Medical Education Foundation is composed of nationally known leaders in business, industry and commerce, as well as the various professions. It is the intention of this group to raise whatever money might be necessary to take up loss of income and provide the means of meeting the higher operating costs of our nation's medical

schools. The A.M.A. fund is merely a segment in the overall effort, with the A.M.A. establishing the mechanics for urging physicians to contribute as much as possible to the cause. This money will be turned over to the National Foundation for distribution among the medical schools.

On July 15, 1951, more than one million dollars was distributed, each medical school in the nation receiving a grant of $15,000 for any use they might desire. Many schools report the gift has enabled them to employ a much neede professor and in some cases to make salary adjustments which were necessary to keep top personnel. Others state the gift has enabled them to purchase some much needed equipment. It is interesting to note that 56 percent of the total funds distributed on July 15 were contributed by members of the medical profession.

It is the feeling of your committee that an effort should be made to support the Medical Education Foundation. Accordingly, the approval of the Council was given the committee on July 15, 1951, for instituting such a program in Indiana. Many other states are giving their full cooperation to this effort of the A.M.A. to prove that our medical schools can be saved from federal subsidy and regulation through the voluntary efforts of the medical profession. It is the hope of your committee that Indiana physicians will accept their responsibility in this cause and will give generously, thus proving we are willing to accept our full responsibility in this fight to save our medical schools from government control.

James W. Denny, M.D., *Chairman*,
Harry P. Ross, M.D.,
Maurice E. Glock, M.D.,
Joseph C. Dusard, M.D.,
Cleon A. Nafe, M.D.,
Philip E. Yunker, M.D.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

The committee points with pride to its success in protecting the public against imprudent health legislation during the 1951 session of the Indiana General Assembly. The April issue of The Journal carried a report of bills passed and defeated, and it is not necessary, therefore, to repeat the details here.

It should be said, however, that the chiropractors made a supreme effort to get through a bill to set up a board of chiropractic examiners. The bill failed to get out of the Senate committee in its original form despite the fact that the chiropractors had eleven paid lobbyists working for them. The committee opposed the bill on the ground that it permitted chiropractors to practice without adequate education.

During the legislative session the committee had the support of three physician members—Senator Walter F. Kelly and Representatives William M. Cockrum and Otis A. Kopp. Having these doctors serving in the legislature was a distinct advantage to medicine, and it is earnestly hoped that there will be doctors in the 1953 session. It is indispensable to medicine to have doctors in the General Assembly, for the influence they exert in the deliberations of the health committees in House and Senate, and otherwise.

The committee has not neglected federal legislation, although the American Medical Association, through its Washington office, is closer to the Washington scene. Letters and telegrams have been sent to Senators and Representatives from Indiana from time to time explaining the state medical association's position on certain bills. In this connection the association has worked with the AMA and followed its policy. We have found the Indiana delegation with one or two exceptions to be sympathetic to our way of thinking.

The election of 1950 saw more friends of medicine elected to Congress from Indiana. The individual doctors were largely responsible for the part they took in the campaign. It is hoped that in 1952 the physicians will again assert themselves, politically speaking.

Donald E. Wood, M.D., and
Norman R. Booher, M.D., *Co-chairmen*
Will Thompson, M.D.
J. R. Doty, M.D.
Harold J. Halleck, M.D.
George R. Daniels, M.D.
R. L. Kleindorfer, M.D.
J. S. Niblick, M.D.
Robert Smallwood, M.D.
John M. Paris, M.D.
James L. Wyatt, M.D.
Daniel D. Stiver, M.D.

COMMITTEE ON PUBLIC RELATIONS

The principal project of the committee has been the issuance of I.S.M.A. NEWS FLASHES to the association membership. Through this news bulletin the committee has tried to present items of interest, and to impress upon the physicians the importance of good public relations. It is the physician in his daily contacts with patients who makes good or bad public relations for medicine. If physicians give good service at reasonable fees, people will speak well of the profession. We have tried to drive home this fact in the monthly letter to members.

Some consideration was given to holding a statewide conference of newspaper and radio representatives in Indianapolis, but the proposal was dropped for this year. It is a big undertaking, and expensive, and the committee could not find time for it. Instead, before the annual session in October, representatives of Indianapolis newspapers, press

associations and radio stations will be guests of the committee at a dinner. Such a dinner was held two years ago, and it seems advisable to "meet the press" again.

The committee has watched with interest the activities of other committees which fall into the category of public relations. Encouragement has been given to these committees.

The Sub-Committee on Physician-Patient Relations, which is a part of the public relations program, has done an excellent job of ironing out misunderstandings between physicians and patients. This sub-committee, however, will submit a report of its own to the House of Delegates.

Earl W. Mericle, M.D., *Chairman*
B. E. Edwards, M.D.
Dale D. Dickson, M.D.
Joseph B. Davis, M.D.
L. N. Ashworth, M.D.
Robert H. Wiseheart, M.D.

SUB-COMMITTEE ON PHYSICIAN-PATIENT RELATIONS

Several complaints have been received by the committee. Practically all have been settled by better understanding between physician and patient, and practically all complaints have arisen due to a lack of understanding between the physician and patient.

We think every physician should emphasize to the patient the cost of laboratory, x-ray and expensive drug treatment before the service is rendered; also, in all cases where the condition indicates prolonged and expensive care and treatment. This will avoid misunderstandings later.

During the year forty-five complaints were received. Thirty were too general and lack of sufficient evidence made them impractical for consideration. At the time of writing this report six cases are pending and nine cases have been adjudicated. Of the nine cases settled six were regarding fees; two regarding information withheld by the physician and one in protest over the length of time it took a physician to make a house call. The committee in its action upheld the physician in seven of the cases. In two cases the committee ruled against the physician, referring the matter to the county medical society for action.

We believe the establishment of this committee has improved our public relations and has aided the association in keeping to a minimum violations of our Code of Ethics.

After due deliberation and our experiences in carrying on the duties assigned us, the committee desires to make the following recommendations:

We recommend that the committee be continued and membership on the committee not be limited to past presidents of the association. We feel the committee should be enlarged, and made a standing committee in order to strengthen its purposes. We concur with the special committee of the Council and desire to support its findings and recommendations.

C. S. Black, M.D., *Chairman*
C. H. McCaskey, M.D.
Charles N. Combs, M.D.
Augustus P. Hauss, M.D.
George R. Daniels, M.D.

SPECIAL COMMITTEE OF THE COUNCIL TO STUDY AND MAKE RECOMMENDATIONS FOR STRENGTHENING THE COMMITTEE ON PUBLIC RELATIONS SUB-COMMITTEE ON PHYSICIAN-PATIENT RELATIONS

Pursuant to the instructions given by the Council of the Indiana State Medical Association, as embodied in the following action taken by the Council at its July 15, 1951, meeting, we respectfully submit our report.

"Following discussion by Drs. Kennedy, Howard and Garner, on motion of Drs. Mitchell and Howard the Council voted to recommend to the House of Delegates that the By-laws be revamped in order that grievance problems may be more adequately handled. The motion provided also for the appointment of a committee from the Council to formulate the procedure to be used in grievance cases, and a copy of the committee's recommendations is to be placed in the hands of each delegate thirty days prior to the 1951 annual convention. The committee appointed by the chairman of the Council to consider this matter consists of Drs. Howard, Reed and Geider."

REPORT ON FINDINGS OF THE SPECIAL COUNCIL COMMITTEE:

Your committee, after due deliberation and meeting with the present subcommittee to the Committee on Public Relations, known as the Committee on Physician-Patient Relations, makes the following recommendations:

1. That proper changes be made in the By-laws of the Association to permit the following:
2. That the committee be made a separate, standing committee, and that it be called "Board of Appeals on Patient-Physician Relations."
3. That membership of the Committee shall be composed of nine physicians, three of whom shall be past presidents of the Association, and all of whom shall be appointed by the president of the Association.

4. That not more than one physician shall be appointed from any one councilor district.

5. That members of the committee shall hold no other elective office during their tenure on the committee.

6. That following the first year all members appointed shall serve for a period of three years.

7. In establishing the new committee, of the nine men appointed, three shall serve for a period of one year, three for two years, and three for three years. Thereafter, during each year three new members shall be appointed for a three-year term.

8. That those so appointed shall organize the committee, electing a chairman, vice-chairman and secretary.

9. That this committee shall receive complaints, appeals, or suggestions from physicians or the laity concerning professional conduct. It shall be a fact-finding committee which shall attempt to adjust differences between patients and physicians. It may, if the facts bear out the complaint, cite the member to the Council of the Indiana State Medical Association, if the committee feels justified in doing so.

10. The Board of Appeals on Patient-Physician Relations, after being appointed and organized, shall draw up a set of rules, regulations and procedures governing the official actions of the Board, which shall be subject to the approval of the Council.

We respectfully request your serious consideration of these recommendations, and we further recommend the adoption of this report by the House of Delegates.

W. H. Howard, M.D., *Chairman*,
Roy A. Geider, M.D.,
William C. Reed, M.D.

COMMITTEE ON PUBLICITY

Your committee has met regularly in the headquarters office during the past year for the purpose of handling newspaper releases, radio and television programs.

"Hints on Health," a regular health column, has been continued and is being used by some 150 newspapers throughout Indiana.

"Hints on Health":

The work of the committee in preparing "Hints on Health" columns is a routine matter but is considered important. We feel it necessary that the public receive accurate and proper information on health subjects. With this thought in mind, the following articles have been released during the past year:

Death on Highways
Rabies
Swat the Fly
Safer Automobiles
Athlete's Foot
Value of Food
Gout
Diabetes
So You Have a Favorite Disease
Lunch Box Nutrition
Atomic Bombing
Watch That Mole
Healthiest Nation
Posture and Health
Watch That Fire
Abdominal Pain
Improving Health Is Dangerous
T. B. Death Rate Drops
Occupational Dermatitis
Childbirth Is Safe
Is It Spring Fever
You Can Eat Potatoes
Lightning
Undulant Fever
Hemorrhoids
Diseases from Animals
Planning That Vacation
Proteins Are Necessary
Hay Fever
Measles
Child Accidents
Beginning Pupils
Good Posture
Immunization Program
When Sickness Threatens
Tonsils
Right or Left Handed
Post-nasal Discharge
Don't Rush
Color Blindness
Crossed Eye
Red Eye
Live with Diabetes
Epilepsy
We Kill Our Children
Infant Nutrition
Headaches
Farmer, Be Careful
Wonderful Blood
Two Kinds of Fog
Thallium Poisoning
Ivy Poisoning
Artificial Respiration
Flies Spread Disease
Accident First Aid
Bank Your Blood
Drug Addiction
Time to Immunize
Keep the Home Safe

General News Releases:

The following general news releases were sent to all newspapers in the state during the year:

Medical School Scholarships
Blood Pressure Readings at Indiana State Fair
First General Story on State Meeting
Awarding of Four Nursing School Scholarships
Out-of-State Speakers at State Meeting
M.D. Scholarship Enables Winslow to obtain Doctor
Nine Complaints are Adjusted by M.D. Committee

Radio Programs:

Station WFBM has continued to carry the weekly transcribed series procured from the American Medical Association, Bureau of Health Education.

The subjects of the programs used were:

Guardians of Your Health
Music with Your Meals

Television Programs:

The committee used the kinescope film prepared by the American Medical Association, Bureau of

Health Education, which was televised through the generosity of television station WFBM. Title of presentation:

Doctor Webb of Horseshoe Bend

Pamphlets:

Your committee, in cooperation with the AMA Campaign Coordinating Committee, the Blue Cross-Blue Shield Plan and the Indiana State Hospital Association, published a total of 1,000,000 pamphlets entitled "Survival Under Atomic Attack." This publication met a need expressed by the Civil Defense authorities for the dissemination of accurate material to the public on how to conduct itself in the event of an atomic attack. Of this total, 200,000 copies were distributed through physicians and their offices, the balance being distributed through hospitals and civil defense channels.

A second publication entitled "Getting Well At Home" is in the process of being printed at the time of preparing this report.

Miscellaneous:

It might be well to report at this time that the following counties are currently using the transcriptions which are available from the Bureau of Health Education of the American Medical Association:

Cass	St. Joseph
Grant	Tippecanoe
Jackson	Vanderburgh
LaPorte	Vigo
Rush	Wayne-Union

The following societies have used these transcriptions in the past but are not using them currently:

Allen	Howard
Daviess-Martin	Lake
Dubois	Monroe
Elkhart	Perry
Floyd	Shelby
Henry	

The Committee on Publicity would appreciate at all times suggestions from the profession for strengthening the usefulness of this committee.

J. O. Ritchey, M.D., *Chairman*
Homer G. Hamer, M.D.
D. S. Megenhardt, M.D.

COMMITTEE ON RURAL HEALTH

The Indiana Rural Health Committee held its first meeting in November to discuss organizational problems and a tentative program for the year ahead. As a result the following objectives were set up:

Immediate Objectives:

1. To invite representatives of rural groups, (County Nurses, Farm Bureau, School People, etc.) to meet with the committee in order to discuss mutual problems, with a view to cooperative planning in the health field.

2. To hold several conferences with local physicians in order to secure their views on medical problems in rural areas. These to be held on a regional basis.

3. To sponsor a series of health lectures for the laity through the medium of Indiana University extension classes.

4. To set up plans to facilitate procurement of M.D.'s for rural areas.

5. To sponsor and plan the annual Rural Health Conference.

Long Range Objective:

1. The formation of a Health Foundation. Such a foundation would assist lay organizations in coordinating health education in the state; help in planning and carrying out of preventive and immunization programs; give direction and help find leadership for county Health Councils; and serve as an overall resource and liaison between the professional and lay groups interested in health problems. It seemed to the Rural Health Committee that this would be a positive and concrete way of indicating that the medical profession is interested in the general health and welfare of the community.

Since this seemed a fairly ambitious program, it was decided that the committee would need to meet every month.

Pursuant to objective one:

Our committee interviewed representatives of the State Board of Health and the County Health Nurses, in addition to talks with many lay leaders. We thought it might be of interest to report that as a result of these interviews, the following criticisms were most frequently levelled at the medical profession:

1. M.D.'s do not participate in community health projects, but complain bitterly if the planning of others does not suit them.

2. The lack of participation becomes an obstruction in many cases, especially in immunization and case-finding projects sponsored by lay groups.

3. Many areas are without medical care of any adequacy.

4. It is becoming increasingly difficult to get M.D.'s to make house calls, particularly at night,

even in cases of real emergency. Some thought the physician was using the scarcity of his product to the disadvantage of the patient.

5. Fees are often out of line, even on a comparative basis, and there is a tendency on the part of physicians to raise fees in cases where the patient has insurance, thereby jeopardizing or nullifying his insurance coverage.

Pursuant to objective two:

Five area conferences were planned: Elkhart, Muncie, Lafayette, Madison and Washington. Plans for these meetings were made by the member of the committee practicing in the area. Four out of these five have been held and have been successful beyond our expectation. The physicians in each of these areas were invited to a dinner meeting where no planned program was offered. Rather a few possible lines of discussion were tossed out and the attending physicians asked to give their views on these, or on any other topic which was bothering them. Representatives of the state medical association were present (Ellison, Wright, Myers, Smith, Waggener, etc.), not to give speeches, but to answer questions—or criticisms! This was an attempt to get the "grass roots" M.D. to bare his chest and, as such, certainly made the grade. Among the "gripes" most frequently mentioned were these:

1. Dissatisfaction with many of the health programs in the state and the manner of conducting them.

2. Resentment of demands made on their time without previous consultation as to convenience or method.

3. A feeling that the medical association is autocratic in its approach and administration. That it makes no attempt to ascertain the views of individual physicians before acting, even when such acts have a profound implication for him.

4. Comment that qualifications other than those of scholastic standards should be taken into consideration when students are accepted in medical schools. The need of physicians with aptitude for the profession, an interest in people as such, and a real "feel" for the important relationships involved in medical practice—as well as high IQ's. Feeling that some of the criticism levelled at physicians comes because of individual unsuitability for the job.

5. Need for more nurses, better methods of student nurse recruitment—especially in small places and rural areas—and more efficient training of aides, so that registered nurses can be saved for the more highly skilled services.

Pursuant to objective three:

Five lectures were sponsored through the South Bend Center of Indiana University. Five physicians, Drs. Marshall Hewitt, Ray Nelson, Frank Scott, Bernard Edwards and Edward Custer, all members of the St. Joseph County Medical Society Speakers Bureau, gave the lectures. They were well received; a questionnaire on the night of the final session indicated an interest on the part of nearly every member in further classes of this type. There were 23 enrolled, with an average attendance of 20. These were regular adult education classes of the Center, requiring registration and the payment of a fee.

Pursuant to objective four:

The placement of physicians in rural areas was intended to be a major project of the committee, but fate intervened in the shape of the war emergency. We were faced with the problem of losing some of the rural physicians we already had, rather than being able to add materially to their number. However, the committee continued to study the problem, with the intention of being ready with plans when the emergency passes. One of the projects carried out was a survey of junior and senior medical students at Indiana University. This survey indicated that eight to one were interested in general practice in rural or semi-rural areas if the following were available:

a. satisfactory place to live
b. satisfactory office facilities
c. hospital within reasonable distance.

Pursuant to objective five:

The third annual Health Conference was planned, as before, to take place at the time of the summer Agricultural Conference at Purdue. Several subcommittee meetings were held with members of the Purdue faculty to plan this conference and the following day's program:

The morning program, with Mrs. Jack Eisaman, Bluffton, chairman of the Rural Health Committee of the Woman's Auxiliary, as moderator, was devoted to a panel on Brucellosis. Taking their cue from Chicago's Dr. Bundesen, "No more milk except that free from Bang's in 1955," and emphasizing Indiana's position as a large dairying state with an economic as well as a health stake in this problem, the following people discussed Brucellosis from their various standpoints: Dan Urschel, M.D., Mentone; F. M. Williamson, D.V.M., Bluffton; Mary L. Moore, H.D.A., Auburn; John Scruggs, D.V.M., State Board of Health. The medical aspects, economic dangers, family and community safeguards, and legal aspects of Brucellosis were covered. A general discussion from the floor was lively and informative, with panel participants eager to answer questions. The panel was followed by an address by Dr. J. J. Moore, Chicago, of the National Brucellosis Committee, entitled "The Nation and Brucellosis."

The afternoon session, profiting by the presence of lay people attending the agricultural programs of the conference, drew many of them into a panel discussing the better use of medical and health services already present in the community. Robert

Yoho of the Board of Health acted as moderator, with J. E. Dudding, M.D., Hope; Herbert Schacht, administrator of the Henry County Hospital, Newcastle; Mrs. Ellen Lockwood, R.N., Osgood; Paul Risk, D.D.S., Lafayette, as discussants. This was followed by Dean Jenkins of the School of Pharmacy at Purdue with a talk on "Miracle Drugs."

The highlight of the Conference was a talk by Dr. George Bond, who has received much national publicity on his Health Center in Bat Cave, North Carolina. His talk was preceded by the A.M.A.'s movie on his project.

Members of the Rural Health Committee attending were: Drs. J. E. Dudding, Frank Sink, Sam Rotman, and Louis E. How. Officers of the state medical association attending were: Dr. Alfred Ellison, president, Dr. J. William Wright, president-elect, Ray Smith, executive secretary, and James Waggener, field secretary.

Conference attendance: A.M. 300, P.M. 575.

Pursuant to the longtime project of the committee, the establishment of a state health foundation, the preliminary plans for this project were drawn up by committee members Habegger and Dudding in conjunction with Albert Stump, attorney for the state medical association. Their plan was presented to the Executive Committee and the Council, and was approved. Since this approval was just given (July) further work will get under way in the fall.

In addition, in cooperation with the Indiana Advisory Health Council, the committee made a survey and prepared a directory of County Health Councils, indicated whether or not they were active, listed their officers and addresses, and any projects carried out in the past, or those on which they were currently working.

As a result of the findings of the Rural Health Committee during this year, we wish to make the following recommendations:

1. Conferences be continued to bring out the thinking of physicians in rural areas. This will also show up potential leaders in the various communities.

2. Make a real effort to find younger physicians and begin to seed them into the state organization by way of committees.

3. Continue to seek positive approaches to the medical and health problems of the state. We feel this will do more than any amount of self-praise in securing and retaining the respect and loyalty of lay groups and individuals.

LOUIS E. HOW, M.D., *Chairman*,
FRANK G. SINK, M.D.,
J. E. DUDDING, M.D.,
WILLIAM E. SCHOOLFIELD, M.D.,
H. N. SMITH, M.D.,
MYRON L. HABEGGER, M.D.,
SAM I. ROTMAN, M.D.

AUDITING COMMITTEE

The Auditing Committee held its annual meeting on July 19, 1951, at the Indiana National Bank, Indianapolis. Investments of the association, as listed below, were examined:

General Fund:

Indianapolis City Hospital bonds	$ 4,000.00
United States Treasury bonds	5,000.00
United States Savings bonds, Series G	32,000.00
	$41,000.00

Medical Defense Fund:

United States Treasury bonds	$ 5,000.00
United States Savings bonds, Series G	13,000.00
	$18,000.00

Cash balances in the Indiana National Bank, the American National Bank, the Fletcher Trust Company, and the Bankers Trust Company, as shown by the June, 1951, bank statements, also were examined. These accounts consist of the General Headquarters Office Fund, the Medical Defense Fund, THE JOURNAL Fund, and the Petty Cash Fund, respectively, and show the following balances as of July 31, 1951:

General Fund	$76,811.64
Medical Defense Fund	4,698.96
THE JOURNAL FUND	15,897.06
Petty Cash Fund	461.50
	$97,869.16

O. B. NORMAN, M.D., *Chairman*
O. O. ALEXANDER, M.D.
HERBERT O. CHATTIN, M.D.

COMMITTEE ON CANCER

Your Committee on Cancer met January 7, 1951, in the Columbia Club, Indianapolis. Members present were: Drs. Russell Malcolm, Mell B. Welborn, Harold M. Trusler, Lall G. Montgomery and Don Bowers. Mr. Rollis S. Weesner, Executive Director of the Indiana Cancer Society, Inc., was guest of the committee.

A communication from the Indianapolis Medical Society requesting closer supervision of cancer publicity in the public press was read to the committee. The communication also recommended closer liaison of county medical societies with their county units of the Cancer Society and described the Indianapolis plan whereby films, literature and releases were reviewed by a committee of the medical society and then released under the joint name of the Medical Society and the Cancer Society. Indianapolis doctors, they reported, were ready to respond to requests to appear before lay groups when cancer films were shown or for other cancer education programs.

Your committee congratulated the Indianapolis Society for its active cooperation and participation

in the cancer control program in that city and recommends such action by all county societies.

The supervision of releases to the public press through the Indiana Cancer Society is controlled by the medical members of its executive committee. Your committee feels that adequate supervision is available and is being given. We wish, however, to call attention to the fact that cancer is a "hot" subject and that publicity releases come from many places and are often beyond control of any local group. Your committee feels that public education, generally, has been excellent and is showing good results in alerting the public to symptoms of the disease and the need for early medical attention. We compliment the cancer society for its efforts.

A review of all cancer control activities during the past year showed expansion of activities and growing interest by the public to aid as they can in bringing this killer under better control.

Your committee feels that too few doctors have taken advantage of the excellent opportunity for increased professional education that is being offered by the Cancer Society and our Medical School. The two day symposium at the Medical Center in April was "tops" in the opinion of the committee, with one exception—that was attendance. We urge that more doctors take advantage of this postgraduate training and that they not "lay aside" all the excellent material coming to their offices.

Your committee wishes further to emphasize that the slogan "Every Doctor's Office a Cancer Detection Center" is sound and can be effective when all physicians prepare themselves and are alert to their opportunity and responsibility in finding malignancies at the time they offer the best hope of being cured.

Again we implore the membership to take advantage of the opportunity for advanced education which is being offered them for the taking.

Russell Malcolm, M.D., *Chairman*
Mell B. Welborn, M.D.
Frank Scott, M.D.
Harold M. Trusler, M.D.
Lall G. Montgomery, M.D.
Don Bowers, M.D.

COMMITTEE ON CHRONIC ILLNESS

Our committee has no report to make at this time. We expect to have a meeting soon and will have a report for the October 29 meeting of the House of Delegates.

F. R. N. Carter, M.D., *Chairman*
Edgar F. Kiser, M.D.
J. T. Oliphant, M.D.
John D. Van Nuys, M.D.
M. C. Pitkin, M.D.

COMMITTEE ON CIVIL DEFENSE

The committee has assumed as its function the stimulation of interest, aid and assistance to county medical societies in preparing for the medical civil defense program. Also, liaison has been kept with the entire civil defense program by having a member on the Governor's Civil Defense Council and members on the Health and Medical Branch of the State Civil Defense organization under Dr. Lee Burney of the State Board of Health. By law, the Director of the State Board of Health is the head of the Health and Medical Branch of each state civil defense organization and is charged with the obligation of its organization throughout the state, as well as promulgating plans and regulations for its operation. The committee has met with the Medical Civil Defense Directors of the target areas and reviewed the local plans previously developed by Marion County, Lake County and South Bend, and by such review has furnished a pattern for the development of a Medical Civil Defense program in the other two target areas; namely, Fort Wayne and Evansville.

The overall State Medical Civil Defense program as it is being developed calls for the maximum effort towards self-help in all target areas. It anticipates the organization for mutual aid from counties surrounding target areas within a radius of fifty miles, such mutual aid to be planned and arranged for by the Medical Civil Defense Directors of target areas with members of the profession who have natural flow and contacts with them. All second class cities in the state will be centers for mobile support units, capable of organizing complete hospital teams, and/or specialized teams for the treatment of fractures, burns and radiation sickness. These mobile support centers may be within the mutual aid areas of a target center; however, unless otherwise arranged for, they will move into a target area only on the advice and direction of the State Director of the Health and Medical Branch.

In addition to plans for manning first aid stations with personnel from mutual aid areas and plans of assistance by organization of first aid, surgical, medical or complete hospital teams from mobile support areas, each county in the state should plan to set up emergency hospital facilities; such as, the utilization of high school or college gymnasiums, preferably located near existing hospitals. It is anticipated that such emergency hospitals will be administered by personnel from existing hospitals but that existing hospitals will not be utilized for the hospitalization of evacuated casualties from an atomic bombed area except for the utilization of x-ray departments, laboratory and surgical facilities to the extent possible.

On the basis of County Medical Society Medical Civil Defense Committee memberships reported to the State Medical Association, it appears that only fair cooperation is being given to the development of the Medical Civil Defense program in Indiana.

Such committees should be organized by each County Medical Society in the state. Their job is to recommend the proper person to be their County Medical Civil Defense Director to the County Civil Defense Director. The committee should then act as an advisory council to the Medical Civil Defense Director of their county and aid him in developing plans and organization for their allotted part of the medical civil defense program.

The target areas in general have well developed organization and plans for their utilization in the event of an atomic attack. Many County Medical Societies outside of target areas have similarly organized and planned to carry out their part in the medical civil defense program. The job ahead is to further stabilize and train these organizations, and to develop and assign every County Medical Society with a firm agreement under a mutual aid pact or mobile support organization. Plans for stockpiling of strategic materials are currently being studied and will be purchased with federal funds matched by state funds and municipal funds.

It must be remembered that an analysis of the casualties resulting from the atomic bombings in Japan indicate that a comparable bomb dropped on any one of the target areas in Indiana would result in the necessity to hospitalize fifty to sixty thousand patients. This would require more beds than exist in all the general hospitals in the state of Indiana. Therefore, it is essential that every county in the state plan for auxiliary hospital space for one thousand or more evacuated casualties. Also, the profession must be so allocated as to permit the maximum care of such a casualty load; while, at the same time, providing for the minimum needs of noncasualty medical care to the normal population.

While the medical profession must take the lead in development of the Medical Civil Defense program, it is essential that the personnel of allied professions be integrated in the overall planning of their organizations. The State Nursing Association is well along with its organization and planning to assist in an emergency. The State Dental Association is ready and willing to do its part. All sections of the State Board of Health are preparing for their functions. The State Pharmaceutical Association is cooperating and the utilization of other professions, such as Veterinarians, Osteopaths and lay personnel trained by the Red Cross, must be considered. The American Radiological Association, at a meeting in February, gave a preparatory course and recommended to its teaching members that instructions in the medical aspects and care of radiation sickness be taught all medical students under the auspices of the Radiological Departments. The State Association of Clinical Pathologists is laying plans to cope with the tremendous demand for blood in the event of an atomic bombing.

The committee appreciates the cooperation which it has received from many sources and particularly from Dr. E. Vernon Hahn, director of the Medical Civil Defense organization for Marion County, and recently named by the Governor to represent the State Medical Association on his Civil Defense Advisory Council.

Glen Ward Lee, M.D,. *Chairman*
Ray Elledge, M.D.
Charles W. Myers, M.D.
Kenneth Olson, M.D.
William O. Baldridge, M.D.
Elmer Singer, M.D.
James M. Leffel, M.D.

COMMITTEE ON CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

Snow and ice on Indiana highways made traveling hazardous on Sunday, January 28, 1951, and held down the attendance at the annual Conference of County Medical Society Officers. Despite the adverse weather conditions, ninety were served at the luncheon.

Dr. John F. Conlin of Boston, who was to have been the luncheon speaker, delayed by two train wrecks and bad weather, was unable to get only as far as Cleveland. While many were disappointed because he failed to arrive, other speakers made the meeting worthwhile.

Dr. A. M. Mitchell was unable to be present on account of illness, and Dr. Alfred Ellison of South Bend presided. Doctor Mitchell was elevated to chairman emeritus of the committee, in recognition of his many years of service as chairman. Dr. Ralph R. Ploughe of Elwood was elected chairman for 1952.

A. M. Mitchell, M.D., *Chairman Emeritus*
Ralph R. Ploughe, M.D., *Chairman*
Frank W. Messer, M.D.
Hugh S. Ramsey, M.D.
Claude D. Holmes, Sr., M.D.
Lall G. Montgomery, M.D.
James P. Gilliatt, M.D.

COMMITTEE ON CRIPPLED CHILDREN SERVICES

The Committee on Crippled Children Services held two meetings during the year, the following minutes of which constitute our annual report to the House of Delegates:

(1) The committee was called to order in the headquarters office of the Indiana State Medical Association on February 25, 1951, at 2:30 P.M., by Dr. Wayne R. Glock of Fort Wayne, chairman.

Present were: Wayne R. Glock, M.D., Fort Wayne, chairman; Carl D. Martz, M.D., Indianapolis; Joseph C. Lawrence, M.D., Evansville; Leland G. Brown, M.D., Muncie; Leo K. Cooper, M.D., Gary; and William B. Ferguson, M.D., Lafayette, committee members. Mr. Robert Branson, Indianapolis office of National Foundation for Infantile Paralysis; Miss Betty Malinka, Gary office of National Foundation for Infantile Paralysis; Frank M. Hall, M.D., Department of Public Welfare, State of Indiana, Indianapolis, and Mr. Ben Bruce, special educational consultant, Services for Crippled Children, Indiana Department of Public Welfare.

Doctor Glock reported actions of the committee at meetings held in March and April, 1950.

After a discussion of the orthodontic handicapped, it was taken by consent that this was a problem to be worked out by the Dental School, the Indiana State Dental Association and the Indiana Department of Public Welfare.

The following resolution was adopted:

Be it resolved that we recommend to responsible agencies dealing with medical care of the indigent crippled, (The Indiana Department of Public Welfare, National Foundation for Infantile Paralysis, Indiana Division of Vocational Rehabilitation, and similar organizations), to establish a uniform means test formulary for their clientele, and when adopted, it be used throughout the state.

The question of disposition of medical insurance held by the indigent patient was discussed at some length, concluding with the adoption of the following resolution:

We recommend to the Indiana Hospital Association that its members set up such hospital admittance procedure that upon the chart of the crippled indigent person it will show whether he or she has medical, surgical or industrial insurance. And furthermore, all patients who have hospital, medical and surgical insurance should be considered as nonindigent unless financial distress can be definitely established.

Some of the problems of medical treatment and policies faced by Indiana chapters of the National Foundation for Infantile Paralysis were discussed by their field representatives.

The program of education of the handicapped child, particularly that of the home-bound youngster, was presented by Mr. Bruce.

The next meeting of the committee will be held Sunday, April 15, beginning with a one o'clock luncheon at Riley Hospital in Indianapolis.

(2) The committee was called to order at the Riley Hospital at 2:00 P.M. on April 15, 1951, with the following present: Drs. Wayne Glock of Fort Wayne, chairman; Carl D. Martz of Indianapolis; Leland Brown of Muncie; William B. Ferguson of Lafayette; Leo K. Cooper of Gary; and Joseph C. Lawrence of Evansville, committee members. Guests included Dr. Frank Hall of the State Department of Public Welfare; Miss Edith Lindley, Social Service Consultant of the State Department of Public Welfare; Miss Betty Malinka and Mr. Robert Branson of the Indiana Chapter of the National Foundation for Infantile Paralysis.

Minutes of the last meeting were read and accepted.

First question discussed was that of the matter of a definition of medical indigency. The polio foundation representatives asked if they would be expected to use the same definition. During the discussion that ensued, it was felt that a standard means test formulary should be used by all agencies that inherent in such a formulary were provisions fitted to the community in which the patient resides. It is felt that no compulsion existed toward the private agencies and that their programs and policies of course must arise with them. The closest cooperation and integration of treatment of all programs operating on behalf of the crippled child is of course desirable.

Miss Lindley then presented the initial draft of determination of financial eligibility in the hospital commitment and placement programs. This had been worked out by Miss Lindley and Doctor Hall in cooperation with the Budget Department and the Division of Public Assistance of the State Department of Welfare. Carefully prepared and very adequately presented, this initial draft was most favorably considered by the committee and the final draft which will be used by the various welfare departments will be made available to the local medical societies.

The following resolutions were adopted after careful discussion:

1. *Be it resolved,* That there be a revision or supplementation of the present medical referral form for crippled children to include information concerning monthly income up to the expenses, hospital, and medical insurance coverage, number in the family, and estimated cost of medical and hospital care.

2. *Be it resolved,* That the National Foundation for Infantile Paralysis be accorded the privilege of presenting an account of the services available to polio victims at the fall meeting of the Indiana State Medical Association. *Further, be it resolved,* to commend the activities of the representatives of the National Foundation for Infantile Paralysis for their splendid work on behalf of the victims of poliomyelitis.

3. Cognizant of the serious implications of the problems of the cardiac cripples, *be it resolved* that further investigation of case finding techniques, adequate treatment program be encouraged, and that the current efforts of the Welfare Department Services for Crippled Children to study this problem be approved.

WAYNE R. GLOCK, M.D., *Chairman*
CARL D. MARTZ, M.D.
JOSEPH C. LAWRENCE, M.D.
LEO K. COOPER, M.D.
LELAND G. BROWN, M.D.
WILLIAM B. FERGUSON, M.D.

COMMITTEE ON DIABETES

The Committee on Diabetes of the Indiana State Medical Association hereby submits its report of activities for the year 1950-51.

The committee has held one meeting during its year of tenure. This meeting was held in Indianapolis, October 29, 1950, and all committee members were present. Discussion was held relative to the Diabetes Detection Drive of November 12-18, 1950.

During the year much correspondence has been carried on by the committee with the American Diabetes Association, with numerous county medical societies, and with lay groups relative to diabetes detection. It is the committee's belief that lay interest is becoming increasingly more manifest in regard to diabetes detection. The cooperation of the American Diabetes Association with this committee has been excellent.

As to the results within the state of last year's Diabetes Detection Drive, thirty-three county medical societies replied to questionnaires sent out by the committee, fifteen counties having had Diabetes Detection Drives, and eighteen counties reporting "no drive." Therefore, only 17.2 percent of the county medical societies of the Indiana State Medical Association reported a Diabetes Detection Drive for last year. This 17.2 percent participation represents a 68.8 percent "effort" on the part of the County Medical Societies, according to American Medical Association estimates, a percentage that the committee hopes will be improved. As a result of last year's Diabetes Detection Drive, 35,898 urine examinations for sugar were reported, of which 429 were found to be positive, an incidence of 1.1 percent.

The committee wishes to thank the members of the association for their cooperation in this worthwhile activity and hopes to see this year an even more concerted effort by the members to detect the unknown diabetic.

Marshall I. Hewitt, M.D., *Chairman*
William D. Gambill, M.D.
Laura Hare, M.D.
Lloyd E. Rosenbaum, M.D.
George W. Willison, M.D.

COMMITTEE ON FOOT HYGIENE

In October 1950 Dr. Alfred Ellison, president of the Indiana State Medical Association, appointed a Committee on Foot Hygiene. The Committee is composed of:

George J. Garceau, M.D.
Harris Shumacker, Jr., M.D.
Wayne R. Glock, M.D.
R. M. McDonald, M.D.
G. B. Underwood, M.D.
Alfred Ellison, M.D. (ex-officio)
L. Edward Gaul, M.D., *Chairman.*

The first meeting was held November 5, 1950, at which time orthopedic and material specifications for a physiologic shoe were discussed. By January 1951 the specifications were decided upon and a large shoe manufacturer who had indicated a willingness to manufacture this shoe was contacted. This source did not materialize. During the spring and summer numerous shoe manufacturers were contacted by mail; and, in addition, the members of the National Shoe Manufacturers Association, in New York, were consulted.

The last part of August we learned of a manufacturer who would be willing to cooperate with the committee. Arrangements are now being made to introduce in the near future a type of footgear meeting the specifications of the committee.

The committee met again on September 23. Drs. Garceau, Underwood, McDonald and Gaul were present. Recommendations of the committee were presented to the Executive Committee. It was voted that the time was not appropriate to take any steps to introduce a physiologic shoe endorsed by the Indiana State Medical Association.

L. Edward Gaul, M.D., *Chairman.*

COMMITTEE ON HARD OF HEARING

The Committee on Hard of Hearing has had no meeting during the past year.

Guy A. Owsley, M.D., *Chairman,*
Samuel M. Baxter, M.D.,
Hugh A. Kuhn, M.D.,
R. R. Calvert, M.D.,
J. C. Travis, M.D.

COMMITTEE ON HEART DISEASE

No report.

INDIANA A.M.A. CAMPAIGN COORDINATING COMMITTEE

The activities of our committee have been conducted on a reduced scale during the past year. This has been in keeping with the pattern established by the American Medical Association. While our activities have not been as intensified as in the past, nevertheless we have been alert and ready to meet any situation that would require the services of this committee, or to carry on any program deemed advisable by the A.M.A.

RESOLUTION CAMPAIGN

Indiana has led the nation in the procurement of resolutions opposing government controlled health insurance. Nearly 25 percent of all resolutions adopted throughout the nation since the beginning of the campaign are from Indiana organizations. We have constantly held our lead and have, today, more than twice as many organizations on record as any other state.

With the coming elections, and as labor organizations continue to take their place beside medi-

cine in the opposition to government medicine, we have been requested by the A.M.A. to renew again our efforts in obtaining resolutions from organizations throughout our state. We have been requested to place special effort on procuring resolutions from labor organizations as well as all other organizations which have not as yet taken this action.

NEWSPAPER ADVERTISING

One ad has been used, so far, during the year 1951. Others are now being prepared for use during the balance of this year. A large ad was placed with all daily newspapers on May 21. The ad featured an exchange of telegrams between Dr. Elmer Henderson and Oscar Ewing. This gained much favorable comment and Dr. Henderson's action resulted in Mr. Ewing's withdrawing from the government printing office the publication in question.

The committee also contributed, along with many other business and industrial firms, a small amount to help finance a series of newspaper advertisments calling attention of the public to the freedoms they now possess and advising that they guard them with all their power.

OTHER PUBLICATIONS

The committee allocated a portion of its budget for the publication of pamphlets which would tend to improve the public relations of the profession. We have cooperated with the Committee on Publicity in this endeavor, seeking its assistance in preparing the copy.

The first of these was the pamphlet "Survival Under Atomic Attack." One million of these pamphlets were distributed throughout the state. A supply was sent to each physician and hospital, the balance being distributed to the public through the official civil defense organization. Many requests for additional copies were received from industrial plants and schools. These were supplied when possible. This endeavor was a cooperative effort between the association, the Hospital Association and the Blue Cross and Blue Shield Plans. Only the generosity of the Blue Cross and Blue Shield made such a wide distribution possible.

The second pamphlet entitled "Getting Well At Home" has been prepared for use by physicians. A copy of the pamphlet is to be mailed or left with the patient who is confined at home with illness. This pamphlet, it is hoped, will be widely used, as it should have a tremendous effect upon the public by creating the feeling that their physician is giving them more consideration than they might have thought. The pamphlet explains many things about providing good care for people who are confined to their homes with illness.

DISTRIBUTION OF LITERATURE

The distribution of literature has continued at a fairly good pace. Several new pamphlets have been prepared by the A.M.A. during the past year. Physicians have been advised of these directly by the Education Campaign Headquarters in Chicago, and the response in ordering additional copies for distribution has been good.

However, many physicians have failed to take advantage of these pamphlets. Our committee would suggest that all physicians check their supply of literature for their waiting rooms, and to reorder many of the newer pamphlets, especially those containing statements of national labor leaders. It is important that we exert every effort possible to place our message in the hands of labor, and work toward bringing more labor support to our cause.

COMMITTEE RECOMMENDATIONS

The coming year promises to be an active one for the physicians of this nation, as well as the many other groups who are interested in putting an end to the trend toward governmental socialism. With coming important elections of 1952, it will require every ounce of strength we can muster to maintain the goals we have reached and to continue our advance to secure the freedoms we desire to maintain. The medical profession as a whole should take a serious view of the economic and social conditions under which we are travelling today—we should be critical in our observations of the proposals being made to us and the American public in behalf of social advancement. We must be prepared to take again the responsibility of leadership in protecting our American Way of Life.

The committee would therefore make the recommendation that the Campaign Coordinating Committee be continued throughout the coming year, and that sufficient funds continue to be made available for use by the committee, so it can carry out any request made by the A.M.A. It is impossible at this time to make a definite statement of plans to be placed into operation. The course of action will probably be established by the A.M.A. Board of Trustees and the House of Delegates during the Los Angeles sessions.

We have exercised judgment in the expenditure of our funds and will continue to do so, and in all probability will return a substantial amount to the treasury of the association. But, until the emergency is over, we consider it advisable that the committee remain prepared to meet the situations as they arise by having adequate funds to carry out the desired activities by this committee.

CLEON A. NAFE, M.D., *Chairman*,
C. H. MCCASKEY, M.D.,
W. L. PORTTEUS, M.D.,
EARL W. MERICLE, M.D.

COMMITTEE ON INDIANA INTERPROFESSIONAL HEALTH COUNCIL

The Indiana Interprofessional Health Council last met at the Columbia Club, Indianapolis, November 15, 1950. Very good representation of members was present. The meeting was in charge of chairman Doctor Jenkins of Lafayette.

A full discussion of subjects coming before the next session of the legislature regarding health matters was reviewed by Doctor Eubank, speaking for the Indiana State Dental Association, Ray Smith for the Indiana State Medical Association, Doctor Burney for the Indiana State Board of Health, Robert Neff for the Indiana Hospital Association, Miss Winkler for the Indiana State Nurses Association, Herbert Gerding for the Indiana Pharmaceutical Association, Doctor Hine for the Indiana University School of Dentistry, Doctor Rice for the Indiana University School of Medicine, Doctor Jenkins and Doctor Niles for Indiana's Schools of Pharmacy.

Dr. L. E. Burney outlined a report on progress of Indiana's Civil Defense Program and the Council approved by motion to support the Civil Defense Program.

It was moved and passed that each member association pay dues of ten dollars a year, and one luncheon each year be paid for by the Council.

Chairman Jenkins suggested that each member association keep the Council informed on any matters that should be considered by the Council and/or member association.

Officers elected for next year are: Chairman—Dr. Glenn L. Jenkins, Vice-Chairman—Dr. E. E. Eubank, Secretary-Treasurer—Henry W. Heine.

E. H. Clauser, M.D., *Chairman*
William C. Reed, M.D.

Ex-officio members:

Alfred Ellison, M.D.
Walter U. Kennedy, M.D.
Donald E. Wood, M.D.

COMMITTEE ON INFANTILE PARALYSIS

Nothing has arisen which would seem to justify a meeting of the Committee on Infantile Paralysis. Since the educational programs for both physicians and nurses were conducted last year and a bulletin on the Care of Patients with Poliomyelitis was published under the joint sponsorship of this committee, it did not seem necessary to repeat this activity so soon. There is, therefore, nothing to report in regard to this committee.

L. T. Meiks, M.D., *Chairman*
Leroy E. Burney, M.D.
R. A. Craig, M.D.
Kenneth T. Knode, M.D.
Charles N. Manley, M.D.

COMMITTEE ON INSTRUCTIONAL COURSES

Your Instructional Course Committee, consisting of the undersigned, has met frequently through the year and has prepared a curriculum of thirty courses which are to be given by capable instructors on Monday, October 29, 1951, as a feature of the annual session of the Indiana State Medical Association. For the first time these courses will be accepted as credit in postgraduate training by the Indiana Academy of General Practice for their membership requirements. It is felt by the committee that the Instructional Course program for 1951 maintains the excellence of and should merit the respectful attention of the membership as have previous courses.

Gordon W. Batman, M.D., and
Russell A. Sage, M.D., *Co-chairmen*
Seth W. Ellis, M.D.
Arthur N. Jay, M.D.
John D. Van Nuys, M.D.
Floyd T. Romberger, Jr., M.D.
J. Lawrence Sims, M.D.
E. Paul Tischer, M.D.

COMMITTEE ON MATERNAL AND CHILD HEALTH

During the time since the last annual meeting of the State Medical Association, the Committee on Maternal and Child Health has had an active and productive year. Three formal meetings were held in January, May and September of 1951, and other activities were carried out individually or by correspondence. A summarization of organized and interim activities are as follows:

AN EMIC PROGRAM FOR THE FAMILIES OF SERVICEMEN

At the request of the Executive Secretary of the Indiana State Medical Association, a report upon the attitude and opinions of the association was prepared for the Committee on Medical Services of the American Medical Association. Briefly, the committee approved a report stating that a program to provide medical and hospital care for soldiers' families would not be opposed providing that the need was made evident and that the state medical associations and the American Medical Association have a part in the planning of any program before it is activated.

SIGHT CONSERVATION

The committee considered a request for advice and consultation to the Medical Advisory Committee of the newly organized Indiana Society for Prevention of Blindness. With the help of many agency representatives, the secretary of the committee prepared a comprehensive report on all existing services in the state for sight conservation, outlining the needs and proposed remedies, and this was approved for the use of the Society

for the Prevention of Blindness and for publication in the April issue of the *Monthly Bulletin* of the Indiana State Board of Health.

PREMATURE CARE TRAINING CENTER

The committee's proposal for the establishment of a training center for nurses in the care of premature infants at Indiana University Medical Center, a major objective of the committee for many years, has finally been realized. A training curriculum and operation procedures have been developed and training courses will be in operation very soon. Under this program nursery personnel from hospitals throughout the state may receive graduate training in the techniques of caring for the premature infant.

ROOMING-IN-CARE FOR MATERNITY PATIENTS AND INFANTS

A rooming-in-care unit for two maternity patients and their infants at the William H. Coleman Hospital in Indianapolis, to be used for demonstration and teaching purposes, was proposed. Since this requires an expenditure beyond the resources of the Medical Center, a plan was approved for the Indiana State Board of Health to provide financial assistance to construct and equip the unit.

PREVENTION OF OPHTHALMIA NEONATORUM

The committee, as it did a year ago, again reviewed the relative merits of the antibiotics and silver nitrate solution for prophylaxis; and it again agreed that silver nitrate was satisfactory and recommended that no change in the regulation of the State Board of Health requiring its use be made at this time.

PERCENTAGES OF CESAREAN SECTIONS IN HOSPITALS IN INDIANA

The numbers and percentages of Cesarean Sections in all hospitals in Indiana for 1949 and 1950, compiled by the Indiana State Board of Health, were reviewed and the wide discrepancies noted. The committee agreed that the discrepancies in rates were very significant and proposed the publication of this material in the state medical JOURNAL. It was later agreed that this matter was so important that it should be brought to the attention of the Executive Committee of the state medical association. The material was presented to the Executive Committee on July 14 and this committee confirmed the action of the Maternal and Child Health Committee and approved of the material for publication.

CRITERIA FOR CLASSIFICATON OF LIVE BIRTHS

The criteria for the Classification of Live Births, previously approved by the committee and distributed by the State Board of Health, was returned for review because it was pointed out that there were some minor discrepancies and some conflicts with the recommendations of the World Health Organization. A special committee again reviewed the criteria to eliminate any discrepancies and to approve a revised criteria for distribution to physicians and hospitals.

BROWN COUNTY HEALTH CENTER PROJECT

In 1943 the Indiana State Medical Association approved of a Public Health Nursing and Nurse-Midwife Service in Brown County, Indiana, because of the lack of medical services in this county and the low economic status of most of the population. The program which has been in operation has met with the approval of the Committee on Maternal and Child Health and the state medical association, but a serious need still exists.

A Health Center Building is the most eminent need since the nursing service has inadequate quarters for offices and clinic facilities. The committee has approved, and has submitted to the Executive Committee of the state medical association, a plan to seek funds from voluntary contribution for the construction of a health center with clinic facilities to be located in Nashville, the county seat in Brown County. The one physician now located in Brown County endorses the program and actively participates.

A prospectus, outlining the poor economic and social conditions and the unusual needs in Brown County, has been prepared by the Division of Maternal and Child Health of the State Board of Health for review by members of the state medical association and any interested philanthropic agencies. The Committee on Maternal and Child Health has unanimously approved of the Brown County program and the Health Center project.

MATERNAL AND CHILD HEALTH PROGRAMS OF THE INDIANA STATE BOARD OF HEALTH

The program activities of the Division of Maternal and Child Health, and the material prepared by the division for distribution or publication were reviewed by the committee. The committee approved of the program activities including assistance and care of premature infants, infants born out of wedlock, The Brown County Midwife Service, the medical program of the Herman G. Morgan Health Center, the Brown County Nurse-Midwife and Medical Care program, the programs for the testing of vision and hearing of children, and other related programs.

Publications prepared or compiled by the division were reviewed and approved, including articles on Cesarean Section Rates in Indiana, the problem of children born out of wedlock, sight conservation and prevention of blindness, and educational pamphlets for parents. The educational pamphlets for parents, bearing a statement of approval by the Committee on Maternal and Child Health of the Indiana State Medical Association, include four dietary guides: *"Food in Pregnancy," "Breast Feeding," "Baby's First Foods"* and *"Feeding the Toddler."*

It is certainly worth reporting to the delegate body that Dr. Neal Baxter, Chairman of the Committee, has received a formal notice from Governor Henry F. Schricker that he has been

appointed to the Governor's Commission for Physically Handicapped Children, to serve a term of four years. This commission was established by Legislative enactment in 1947.

The Committee on Maternal and Child Health will have concluded its activities for the current year on a note of sorrow. It expresses its sincere regrets at the loss of a dear friend and a helpful co-worker, Mr. Ray Smith.

NEAL E. BAXTER, M.D., *Chairman*
E. R. CARLO, M.D.
ROBERT E. JEWETT, M.D.
G. W. GUSTAFSON, M.D.
REX W. DIXON, M.D.
C. O. MCCORMICK, SR., M.D.
H. W. EGGERS, M.D.
CARL P. HUBER, M.D.
LYMAN T. MEIKS, M.D.

COMMITTEE ON MEDICAL AND NURSING SCHOOL SCHOLARSHIPS

The Committee on Medical and Nursing School Scholarships met on April 25, 1951, to prepare a list of localities in Indiana deemed critically in need of a physician, for submission to Drs. Fred W. Dierdorf and Carl H. Ault, scholarship recipients who were completing their internships on June 30, 1951, for them to select one of their choice. The two physicians had each received $1,500 from their scholarships, and were at liberty to practice for at least four years in one of the towns to fulfill their agreements, or repay the money with 4 percent interest from the date payments were made to them.

The decisions were as follows: Doctor Dierdorf selected Winslow, and opened his practice immediately in the office of the late Dr. L. R. Miller. Doctor Ault elected to pay back the money and has signed six $250 notes payable at six months intervals.

Of three scholarship-holders finishing their internships to date, (one last year) two have elected to pay back the money and one, Doctor Dierdorf, chose to enter rural practice. Since the scholarship fund was established to encourage rural practice, the committee feels that the placing of only one of three scholarship recipients in rural areas is only a fair return for the effort. However, the decision of Doctor Dierdorf to select Winslow has caused much favorable comment throughout the state, particularly because of a feature article dealing with Doctor Dierdorf and Winslow which appeared in an early August issue of the *Indianapolis Times*.

The action of the House of Delegates in 1950 in dropping the scholarship fund in favor of a rotating loan fund for medical and nursing students created a problem which caused your committee to consult with the Executive Committee. The difficulties associated with any kind of loan fund were increased in that the students to be helped would be scattered throughout the state, in the case of nursing students particularly. The Executive Committee recommended to this committee that it withhold the making of loans prior to the meeting of the House of Delegates in October 1951, thinking it imprudent to begin a student loan program pending House action. The Executive Committee and the Council voted to request the House of Delegates to abolish student loans on account of the difficulty of making these loans and collecting them.

Those scholarships now in effect will be carried through to term.

JAMES M. KIRTLEY, M.D., *Chairman*
JAMES L. LAMEY, M.D.
PAUL J. FOUTS, M.D.

Ex-officio:

ALFRED ELLISON, M.D.
WALTER U. KENNEDY, M.D.
DONALD E. WOOD, M.D.
NORMAN R. BOOHER, M.D.

COMMITTEE ON MENTAL HEALTH

Your Committee on Mental Health has held one formal and a number of informal meetings during the year. The most important matters considered are as follows:

1. On November 22, 1950, the committee was alerted by Mr. Ray Smith to the fact that a group within the Indiana Psychological Association was again preparing a bill for licensure of "Clinical Psychologists." Support of the I.S.M.A. for the bill was requested by Delton C. Beier, Ph.D., president of the Indiana Psychological Association.

Your Committee on Mental Health studied this bill and considered it to be in conflict with the Medical Practices Act and to open the way for the establishment in Indiana of a healing cult authorized to treat mental illnesses without benefit of adequate training in the sciences necessary for valid psychiatric diagnosis.

For greater strength in opposing the proposed legislation, your Committee on Mental Health enlisted the support of committees of the Indiana Neuropsychiatric Association and of the Indianapolis Medical Society. Conferences were held with representatives of the Indiana Psychological Association in an effort to gain such modification of the bill that it could be approved by physicians.

These conferences invariably led to heated discussion which failed to bring about a satisfactory solution. The physicians participating in the conferences could conclude only that the psychologists were determined to seek licensure on terms permitting them to treat mental illnesses under such legal certification as is presently vouchsafed only to properly qualified doctors of medicine.

A combined report of the committees of the three medical organizations was prepared and submitted to the Executive Secretary of the I.S.M.A. for submission to the legislature committee concerned with the bill introduced by the psychologists. The bill failed to get committee recommendation and did not come before the legislature for action.

The assistance of Mr. Albert Stump in bringing to sharp focus many legal ineptitudes of the proposed legislation was most valuable to your committee and is herewith gratefully acknowledged.

It would require too much space to present here all of the reasons why the I.S.M.A., in the opinion of your committee, should continue to exercise the *utmost watchfulness in the future* to prevent the enactment of legislation licensing psychologists to treat mental illnesses without the supervision of physicians qualified as psychiatrists. The most important reason, however, claims attention. The legal establishment of a school of mental healing divorced from medical science would be a backward step toward the mysticism of the Middle Ages.

Support of the attitude of your committee in this matter was afforded by the action of Governor Dewey in vetoing a similar act which succeeded of passage in New York. There, as here in Indiana, passage of the bill was urged as a protection of the public against "quacks" in the field of psychology. Said Governor Dewey, "There is no question but that the public should be protected from charlatans, but there are already penal statutes which deal with false representations." He added, "There has been no showing as to the extent to which frauds evade these provisions." He further criticized the legislation as failing to give "adequate recognition" to the distinction between psychology and psychiatry.

Further support of your committee's policy was afforded by Daniel Blain, M.D., Medical Director of the American Psychiatric Association, who reported the opinion of the Council of that organization as follows: "The Council of the A.P.A. is strongly opposed to independent private practice of psychotherapy by clinical psychologists" and "The Council feels that psychotherapy, whenever practiced, should be done in a setting where adequate psychiatric safeguards are provided."

2. At the mid-winter meeting of the secretaries, your Mental Health Committee included in its interim report some data concerning the Indiana Mental Hygiene Society. The substance of the report was that this society had made considerable growth, that it had been very effective in supporting legislation consistent with the aims of the I.S.M.A., and that its leadership was receptive to medical (psychiatric) guidance.

At this time it should be reported that financial difficulties required the Mental Hygiene Society to relinquish the services of its director, Mr. Walter Argow. It is hoped that readjustments within the Society may soon lead to the employment of a part-time director. The question of affiliation of the Indiana Mental Hygiene Society with the National Association for Mental Health has not been settled.

Your Committee on Mental Health again recommends to the county societies that they interest themselves in the local chapters of the Indiana Mental Hygiene Society. It is felt that these groups need medical guidance and that the public relations of the medical societies will be improved by such cooperation.

E. Vernon Hahn, M.D., *Chairman*
John Hare, M.D.
Murray DeArmond, M.D.
Louis W. Nie, M.D.
H. C. Dunstone, M.D.

COMMITTEE ON MILITARY MANPOWER

Creation of the Committee on Military Manpower resulted from action at the time of the last state medical association meeting when World War III appeared imminent and there was a need felt to see that medical manpower in the state would be properly used.

An interim report on the activities of this committee can be found in the state medical Journal. These reports were given at the January meeting of the county secretaries, and at the spring meeting of the Council of the state medical association. To summarize all the activities of the committee would require more time than allotted and be an unnecessary repetition of information seen in the medical Journal and newspapers.

Advisory action, interpretation of selective service regulations regarding doctor registrants under current draft act, and assisting the County Manpower Committee with its problems, have been a large part of the duties of the committee. They have also been called upon to classify reserve officers as to relative military priority and availability; to prepare and transmit information on draft registrants living in this state and registered elsewhere. They have transmitted information from the National Advisory Committee to selective service, selective service regulations and reserve officer directives to the county committees and to the doctors directly interested in military service.

The requirements of doctors for the armed forces have been met without exhausting the supply in Priority I category in the draft and their counterparts in the reserves. Unless the war situation worsens, the supply of doctors for the armed forces can be maintained from registrants in draft Priorities I and II (those whom Congress feels owe the greatest obligation to enter military service) and their counterparts in the reserves.

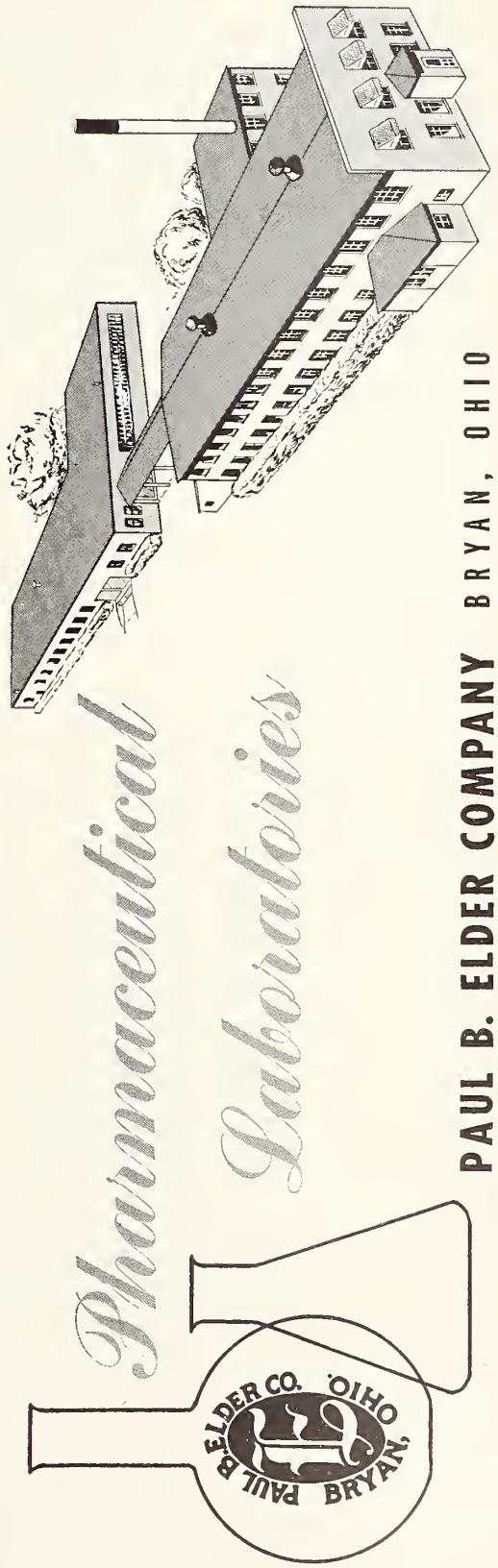
INDIANA STATE BOARD OF HEALTH
Division of Communicable Disease Control

MONTHLY REPORT—JUNE 1951

Disease	June 1951	May 1951	April 1951	June 1950	June 1949
Brucellosis	4	0	1	6	6
Chickenpox	82	156	224	131	94
Conjunctivitis	3	9	8	0	3
Diphtheria	10	6	9	4	19
Dysentery,					
Amoebic	3	0	0	0	0
Bacillary	2	1	0	I	0
Shigella	1	0	0	0	0
Encephalitis	2	3	I	4	2
Food Infection	I	3	0	9	I
Impetigo	3	5	0	0	0
Influenza	23	38	20	0	2
Infectious hepatitis	13	9	II	0	0
Malaria	1*	0	0	0	0
Measles	374	645	705	II67	545
Meningitis,					
Unclassified	5	6	7	I	3
Meningococcal	2	2	4	3	3
Staphylococcal	1	0	0	0	0
Mumps	183	292	225	74	99
Pneumonia	52	44	52	25	I6
Poliomyelitis	I2	I	2	5	10
Rabies in animals	63	58	49	62	62
Rheumatic fever	1	5	0	0	I
Rocky Mt. Spotted fever	2	1	0	3	2
Rubella	41	216	287	39	107
Scarlet fever	43	102	207	47	59
Septic sore throat	8	5	0	0	0
Tetanus	1	1	0	0	2
Tuberculosis,					
Pulmonary	149	I78	164	174	I8I
Other forms	9	7	22	15	15
Typhoid fever	2	2	0	4	4
Vincent's angina	8	1	I	1	0
Whooping cough	97	135	51	137	81
Hookworm disease	2	0	0	0	0
Psittacosis	I	0	0	0	0

* Contracted in Korea

Important messages are presented in the advertisements in THE JOURNAL each month. New products are announced from time to time, and information is presented regarding the use of products featured. Other types of ads emphasize services rendered and commodities offered that may be used in your practice, in your office, and in your home. Please tell the advertisers that you saw their ads in THE JOURNAL of the Indiana State Medical Association.





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At the present rate of active duty call-ups, this source of medical supply will last until March, 1953.

It is estimated that about 400 doctors are the total number which will be involved in this state. Not more than two-thirds of this number will be in uniform at one time; some will be returning before the last are called. There are over 4,400 licensed physicians in the state and the loss of 6 percent of the doctors to the armed services should not result in any serious breakdown in adequate medical care.

The greatest problem resulting from call to duty of these doctors is in depletion of resident hospital staffs and in a few of the smaller communities of the state.

The state committee feels that the county committees deserve high praise for their care and consideration in performing the necessary, but at times unpleasant task, to decide whether their conferees should be declared available for military service. This will never be a pleasing or sought-after duty. It is strongly recommended that the personnel of these committees remain unchanged so far as possible.

The committee feels that the necessary upset in hospital residency programs cannot be helped and the hospital staffs are urged to help in the present problem by shouldering more of the routine responsibility to their patients.

There has been no provision made for re-assignment of physicians to cover medical care in areas where doctors are required to leave for the armed services. The cooperation of the county society in seeing that the practice of doctors called to the services is adequately cared for is an important step toward maintaining good public relations.

In closing, it is emphasized that the action of the County and State Manpower Committees is advisory and the responsibility for doctors entering military service is a matter of public legislation under the selective service act.

John E. Owen, M.D., *Chairman*,
Charles F. Thompson, M.D.,
Gayle J. Hunt, M.D.,
Herman T. Combs, M.D.,
Carl G. Miller, M.D.,
H. M. English, M.D.,
Gordon A. Thomas, M.D.

COMMITTEE ON NECROLOGY

The business of this committee is to compile a record of the deaths of Indiana physicians each year, listing their ages, society affiliations, date of death, residence, and cause of death. This report is prepared and published annually in the earliest possible edition of The Journal.

James B. Maple, M.D., *Chairman*
E. B. Jewell, M.D.
W. D. Inlow, M.D.

COMMITTEE ON PHYSICIAN-HOSPITAL RELATIONSHIPS

The Committee on Physician-Hospital Relationships had four meetings during the year. The aim of this committee was to implement the resolutions of the Committee on Hospitals and the Practice of Medicine of the American Medical Association, which is commonly referred to as the "Hess Committee." The House of Delegates of the Indiana State Medical Association passed a resolution last September at French Lick, reaffirming the principles laid down in the "Hess Report."

Your committee has initiated a program of education on these issues which concern a principle of ethics that dates back to Hippocrates; namely, that the primary duty of the physician is to his patient. The "Hess Report" states that:

1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called, or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

2. The practice of anesthesiology, pathology, radiology and physical medicine are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine.

3. The hospital service plans, as Blue Cross, should exclude all medical services; medical service plans as Blue Shield, should include Anesthesiology, Pathology, Radiology and Physical Medicine. The Hess Report recommended that Blue Shield and Blue Cross be requested to cooperate to the extent of writing all new contracts in such a manner that Blue Shield will cover insurable medical services and Blue Cross will cover insurable hospital services.

The educational campaign of the committee included the following:

1. The committee sent a questionnaire to the members of the Indiana State Societies of Anesthesiology, Radiology, and Pathology. We received a 40 percent response from this survey and the opinions stated were unanimous in their support of the principles of the "Hess Report."

2. The Committee sent a letter to each County Medical Society stating the issues involved in the "Hess Report," urging a discussion of these issues and urging the appointment of a local committee on Physician-Hospital Relationships.

3. A letter was sent to all hospital Boards of Trustees in Indiana informing them of the principles of ethics involved in the "Hess Report"; and also pointed out that this report showed a way for a better basis of cooperation and understanding between hospital authorities and physicians.

On May 6 the committee met with the Executive Committee of Mutual Medical Insurance. Discussion by members of the executive committee of Mutual Medical Insurance brought out a reluctance for any change in the present method of indemnifying professional services rendered by anesthesiologists, radiologists or pathologists. It was indicated that OSTEOPATHIC physicians can be indemnified by our present plan in Indiana; yet members in good standing in the Indiana State Medical Association, in certain specialty groups, are denied this privilege.

From a report made to the Executive Committee of the Indiana State Medical Association, May 26, concerning encroachment on the hospital rights of physicians and particularly of the general practitioner, it is evident that better medical staff organizations in our hospitals in various parts of the state are necessary in order to obtain better relations not only between physicians but also between physicians and hospital administrators and trustees.

The committee was represented by Drs. Haymond, Beeler, Kahler and Lane at a joint meeting of representatives of the Indiana Hospital Association, Indiana State Nurses Association, and the Indiana State Medical Association, to hear a report on the Peru and Marion hospital difficulties. At this meeting the groundwork was laid for further joint discussions between the Indiana Hospital Association, the Indiana State Nurses Association and the Indiana State Medical Association in order to improve physician-hospital relationships.

Considering the obvious need for improvement in physician-hospital relationships, not only from the standpoint of a principle of medical ethics involved in the hospital relationships of certain medical specialties, but also for the need of improvement in medical staff organizations and improvement in the relations of these staffs with other members of the hospital organizations, this committee resolves:

WHEREAS: A continuous and long range program is necessary to solve the problem of physician-hospital relationships, and

WHEREAS: The majority of differences between physicians and hospitals must be worked out at a local level, and

WHEREAS: The Board of Directors of Mutual Medical Insurance have not seen their way clear to make adequate response to recommendations of the Indiana State Medical Society House of Delegates, and

WHEREAS: The House of Delegates of the American Medical Association in June 1951 reaffirmed the principles of the "Hess Report" and recommended that they be adhered to in discussions now in progress with representatives of the American Hospital Association in setting up the joint hospital standardization program, *Therefore, be it resolved that:*

1. The work on the aims of this committee be continued, and

2. The Indiana State Medical Association urge physicians to settle their differences with hospital management by conferences at the local level, through proper staff organizations, and

3. The House of Delegates specifically instruct the Board of Directors of Mutual Medical Insurance to arrange for coverage of the medical services of the anesthesiologists, radiologists and pathologists in hospitals under the Blue Shield Plan at the earliest feasible time as a matter of absolute necessity in protecting the ethical standards of our professions.

WILLIAM H. LANE, M.D., *Chairman*
JOSEPH L. HAYMOND, M.D.
WILLIAM C. WRIGHT, M.D.
RAYMOND C. BEELER, M.D.
GEORGE K. MAY, M.D.
MAURICE V. KAHLER, M.D.

COMMITTEE ON PREPAID MEDICAL AND HOSPITAL INSURANCE

This committee met on official call of the chairman July 29, 1951, at Indianapolis. The following members of the committee were present: Dr. I. C. Barclay of Evansville, Dr. Bruce Stocking of Muncie, Dr. Virgil McCarty of Princeton and the chairman, Dr. A. P. Hauss of New Albany. Mr. R. S. Saylor, executive vice-president of Mutual Medical Insurance, Inc.; Edward B. Morris, enrollment director of Blue Cross-Blue Shield, and Mr. Ray E. Smith, executive secretary of Indiana State Medical Association also attended the meeting as consulting guests.

The committee respectfully presents to the 1951 House of Delegates the following resolution:

WHEREAS: The 1945 House of Delegates of the Indiana State Medical Association authorized the incorporation of Mutual Medical Insurance, Inc., after a ten year study had been made and reported by the Permanent Study Committee on Medical Care Insurance, and

WHEREAS: The Indiana State Medical Association sponsored the organization of Mutual Medical Insurance, Inc., for the following specific purposes:

1. To provide prepaid medical care insurance to aid the lower income groups in the cost of their catastrophic illnesses.
2. To foster better physician-patient relationship.
3. To provide a long range answer to those who say only the Government can provide the low income groups with adequate medical care they can afford, and,

WHEREAS: The Indiana Blue Shield Plan, organized in 1946, is now one of the fastest growing physician sponsored Plans in the nation, having paid out to date more than $5,000,000.00 for physician's services and has enrolled nearly three quarters of a million members in Indiana, and

WHEREAS: Similar physician sponsored prepayment medical care plans are now being presented by more than 72 Blue Shield plans in 41 states and several Canadian provinces, and

WHEREAS: There is considerable divergence in the contracts, membership eligibility, fee schedules, insurance coverage, etc., among these physician sponsored plans, and there will be continued development, changes and trends due to further experience, economic, actuarial and political developments, and

WHEREAS: The success or failure of our Indiana Blue Shield Plan will directly reflect on the Indiana State Medical Association; therefore

Be It Resolved, that the Indiana State Medical Association continue a close alliance with Mutual Medical Insurance, Inc., by reestablishing a Permanent Study Committee on Prepaid Medical Care Insurance in order to safeguard against the possibility of Government medicine ever again becoming a threat or a need in Indiana.

Be It Further Resolved, that the 1951 House of Delegates mandate the President of the Indiana State Medical Association to appoint annually a Permanent Study Committee composed of not more than fifteen physicians who geographically represent the various areas of the state.

This committee shall act as a fact finding body to carry on a continuous and unbiased study of the physician sponsored plans in operation throughout the nation, and also the medical insurance plans and policies offered or proposed by commercial companies, cooperative lay groups, and industrial employers and employee interests.

Its study of medical care insurance development, trends, coverage, policies, fee schedules, administration, enrollment, actuary principles and public need shall be reported periodically and without prejudice to the association membership through THE JOURNAL or by other means deemed advisable.

The committee or its authorized representatives may meet with or present factual information to the Board of Directors of Mutual Medical Insurance, Inc., when requested and shall make an annual report to the House of Delegates.

Be It Further Resolved, that this Permanent Study Committee be appointed to replace the present committee on Prepaid Medical and Hospital Insurance.

Be It Further Resolved, that this House of Delegates commend the officers, directors and administrative employees of Mutual Medical Insurance, Inc., upon the successful administration of Indiana's Blue Shield Plan.

We recommend the adoption of this resolution.

AUGUSTUS P. HAUSS, M.D., *Chairman*
I. C. BARCLAY, M.D.
BRUCE STOCKING, M.D.
A. F. WEYERBACHER, M.D.
VIRGIL MCCARTY, M.D.
LEE J. MARIS, M.D.
WM. A. KARSELL, M.D.

COMMITTEE ON SCHOOL HEALTH AND PHYSICAL EDUCATION

The field of school health and physical education is so broad and its ramifications are so numerous, that it was deemed wise by the Committee on School Health and Physical Education to define and adopt a statement clarifying the purpose of the committee as follows: "The purpose of this committee shall be to aid in the development and promotion of health and physical education programs for the school children of our state and our nation, in the belief that our profession may contribute to an ever increasing level of health and thus help build more firmly one of the most important foundations of what we choose to call the American Way of Life." As a corollary to the stated purpose of the committee, an objective for this year was adopted. This is to formulate minimum acceptable standards for school health and physical education programs on several different levels depending on the type and size of the various school systems.

After consultation with representatives of the American Medical Association, the Indiana School Boards Association, the Indiana School Superintendents Association, the Indiana State Department of Public Instruction, the Indiana State Board of Health, the Indiana State Dental Association, and the Indiana State Medical Association, the conclusion was reached that a state-wide School Health Conference similar to the one conducted by your committee in 1948 would present the most practical method of accomplishing our purpose and would at the same time furnish the most effective means of securing the active cooperation of all interested parties in forming and successfully operating these health programs.

Consequently, plans are practically complete for such a Health Conference to be held on September 26, 1951, at the Claypool Hotel in Indianapolis.

Your committee wishes to emphasize that the central theme, which will run through the entire conference, is that the school health program of every community must be formulated and carried out at the local level through cooperation of local school officials, and local medical and dental association representatives. The function of the conference will be twofold. First, it will be educational. Secondly, it will attempt to bring together school officials and medical and dental association members and to stimulate them to work together.

It is hoped that a complete report of the conference may be presented in a later issue of THE JOURNAL.

G. O. LARSON, M.D., *Chairman,*
JOSEPH H. CLEVENGER, M.D.,
FRANCIS P. JONES, M.D.,
GEORGE V. CRING, M.D.,
N. C. ISLER, M.D.,
L. M. MCNAUGHTON, M.D.

COMMITTEE ON STATE FAIR

It must be realized that the report of this committee was prepared prior to the actual carrying out of the program of the committee. At this writing it is possible to give only the plans of the committee and perhaps the results of its activities may be made in a supplemental report to the House.

The Indiana State Fair was held from August 30 to September 7, 1951. Your committee was successful in obtaining the approval of the Board of Trustees of the American Medical Association for the showing of their exhibit on Medical Quackery. This exhibit was manned at all times by

representatives of the Bureau of Investigation of the American Medical Association.

The taking of blood pressures was again a feature attraction of the exhibit.

The women of the Auxiliary to the Indianapolis Medical Society gave generously of their time as hostesses at the booth in distributing literature to all those in attendance and assisted in many other ways.

M. O. Scamahorn, M.D., *Chairman*
William D. Province, M.D.
Lowell F. Beggs, M.D.
Mathias S. Mount, M.D.
Ralph R. Ploughe, M.D.

COMMITTEE ON TRAFFIC SAFETY

After much discussion about traffic and traffic safety, we concurred on the following resolutions which we submitted to the Committee on Traffic Legislation of the State Legislature:

1. Revision of the present law compelling doctors, under heavy penalty, to report all epileptics, as such, which violates the rights of privileged communication. Replacement of such law by one providing for the reporting of ANY "physical condition which renders the patient unfit for driving"; the exact diagnosis to be given only on demand and with permission of the patient.

2. Provide the Indiana State Police system with adequate personnel to administer and enforce the traffic laws and program, said increase to be accomplished as such personnel can be trained and absorbed efficiently. We suggest some plan be worked out between state, city and county traffic enforcement personnel so that better and more efficient coordination be accomplished.

3. In addition to tax receipts, either evidence of insurance or a paid-up bond in the amount of $10,000, said financial responsibility to cover the period of validity of the license before a driver's license is issued. We believe this is the necessary step to insure financial liability in case of accident, a part of the present law which is not too well complied with.

4. We wish to commend the high school drivers training program, of class room instruction and behind the wheel experience, and recommend that this be extended and enlarged as quickly as it is efficiently possible over the state.

5. We recommend more intensive study and use of highway signs, stoplights, including 4-way stops at intersections. We recommend this study particularly at intersections of high accident rate.

G. T. Bowers, M.D., *Chairman*
Ralph C. Eades, M.D.
David Hadley, M.D.
O. E. Wilson, M.D.
C. Philip Fox, M.D.

COMMITTEE ON TUBERCULOSIS

The Committee on Tuberculosis appointed by Dr. Alfred Ellison found it unnecessary to hold a meeting, but has been functioning by correspondence. This committee passed the following resolution which was endorsed by the Indiana Tuberculosis Association and the Indiana Chapter of the American College of Chest Physicians:

WHEREAS: The Blue Cross Hospital Service allows 14 days hospital benefits for cases of tuberculosis in each year and no half benefits,

WHEREAS: Other diseases are paid 30 days full benefits and 30 days half benefits each year,

WHEREAS: The American Medical Association and the American Hospital Association have recommended most general hospitals provide facilities for the treatment of pulmonary tuberculosis,

WHEREAS: Modern surgical methods are necessary in the control of tuberculosis and patients are often kept in the hospital at least 30 days,

Be It Resolved: That the Blue Cross Hospital Service be requested to allow cases of tuberculosis the same benefits as other diseases.

One member of the committee, Dr. L. A. Malone of Terre Haute, filed the following minority report, to-wit: "I am only in favor of calling the attention of the Blue Cross Hospital Service to the apparent inequity of their benefits with a request that they study the situation." Doctor Malone feels that it is not our place to tell an insurance company what its benefits should be.

The following report was received by all members of the Committee on Tuberculosis from the Indiana State Board of Health. These details are published for your inspection, criticism, approval or disapproval. This program was approved in general last year, but not in this detail.

To meet several requests for specific procedures to use as a guide in determining how to proceed with adequate follow-up on contacts, particularly for children under 15 years of age, as to tuberculin status, and exposure status, the following has been made to use as a guide for nurses and others who assist with the follow-up procedures for local clinic or community control programs.

All individuals who were living in a household with an open case of pulmonary tuberculosis, or who were in intimate association with an infected case of tuberculosis, in the home or elsewhere, are considered contacts. It is most desirous that the exposure to an open case of pulmonary tuberculosis be broken as soon as possible for all children and young adults, but especially for children under 3 years of age.

It is advisable that local medical approval of these specific procedures be sought before they are used locally.

Infants Under Three Years

If or when contact *is* or *is not* broken.

Tuberculin-negative

Tuberculin test every 3 months and x-ray

according to the recommended procedure under "Tuberculin-positive."

Tuberculin-positive

X-ray at least every 6 months or more frequently as requested by the attending physician until 3 years of age.

If exposure has been excessive or on the advice of the attending physician, this procedure might be extended for another two or three years to ferret out any incipient reactors.

Children Three to Twelve Years

1. If or when contact *is* broken.

Tuberculin-negative

X-ray once, if x-ray is negative do not schedule further examination until child is 12 years of age.

Tuberculin-positive

a. X-ray once and if found negative, do not schedule further examinations until child is 12 years of age.
b. If x-ray is positive, clinical follow-up will depend upon recommendation of attending physician.

If child has a history of marked exposure, it might be advisable to continue periodic examinations, including tuberculin tests and/or x-ray for a period of two years, at six-month intervals.

2. If or when contact *is not* broken.

Tuberculin-negative

Tuberculin test every 6 months, x-ray as recommended in the procedure "Tuberculin-positive."

In some instances, upon the advice of the attending physician, the tuberculin test may be given more frequently.

Tuberculin-positive

X-ray every 6 months for the first two years and yearly thereafter until the age of 25 or until 3 years after contact is broken. If significant findings are apparent individual recommendations of the attending physician should be followed.

Children Twelve to Fifteen Years

If or when contact *is* or *is not* broken.

Tuberculin-negative

Tuberculin test every 6 months, for at least a two-year period, or until test becomes positive, then x-ray according to the recommended procedure under "Tuberculin-positive."

Tuberculin-positive

X-ray every year until 25 years of age, if x-rays are negative for significant findings, or until three years after contact is broken. More frequent examinations may be indicated by the attending physician if suspicious or positive findings are apparent during this critical age.

(Note: When conversion from a negative to a positive tuberculin reaction takes place, it may indicate more frequent supervision than is indicated above and the recommendation of the attending physician should be sought.)

New Contacts—Children Ten to Nineteen Years

Contacts from 10-15 are to follow the same outline as indicated under "Children 12 to 15 years."

If contact *is* or *is not* broken, examine at six-month intervals during the first two years and yearly thereafter until the age of twenty-five years, or until three years after the contact is broken.

New Contacts—

Children Fifteen to Nineteen Years

Tuberculin-negative

Tuberculin test every 6 months for at least two years. If the child becomes positive during that period, x-ray according to the recommended procedure under "Tuberculin-positive."

Tuberculin-positive

X-ray every year until 25 years of age, if x-rays are negative for significant findings, or until three years after contact is broken. After conversion, x-ray at least every 6 months for a period of 1 or 2 years.

More frequent examination may be indicated by the attending physician if suspicious or positive findings are apparent during this critical period.

(Note: When conversion from a negative to a positive tuberculin reaction takes place, it may indicate more frequent supervision than indicated above and the recommendations of the attending physician should be sought.)

Adults Twenty to Twenty-Nine Years

1. If contact *is* broken, x-ray at six month intervals for the first two years of observation and yearly thereafter for three years.
2. If contact *is not* broken, x-ray at six month intervals for the first two years of observation and yearly thereafter as long as contact is exposed to an open case of tuberculosis.

Adults Thirty Years and Over

1. If contact *is* broken patient may be discharged for clinic if their third x-ray taken at yearly intervals after contact is broken proves negative.
2. If contact *is not* broken, x-ray at least at yearly intervals as long as contact is still exposed to an open case of tuberculosis.

"In clinics where the cost of films or the inconvenience of patients returning to the clinic makes it impossible to carry out so complete a system of contact examination, it is suggested that—

a. Children over three who show no evidence of pulmonary tuberculosis receive no further examination until the age of fifteen, and if the roentgenogram is then negative, that they may be dropped.

b. Adolescents aged fifteen and over, if negative on first examination, be followed for two more years with annual roentgenograms."

As chairman, I wish to express my appreciation to all committee members for their prompt attention to all correspondence. Because of your cooperation this committee functioned without expense to Indiana State Medical Association.

Paul D. Crimm, M.D., *Chairman*
Russell S. Henry, M.D.
O. T. Kidder, M.D.
L. A. Malone, M.D.
Lloyd C. Marshall, M.D.
Robert B. Sanderson, M.D.
Robert A. Staff, M.D.
James H. Stygall, M.D.

COMMITTEE ON VENEREAL DISEASE

There has been nothing referred to the Committee on Venereal Disease during 1951. The chairman has retained close relations with the State Health Department in regard to venereal diseases and there has been no change in policies already approved by this committee and ratified by the House of Delegates. The venereal problem has not presented any unusual developments and hence no meeting has been called.

Minor Miller, M.D., *Chairman*
T. D. Rhodes, M.D.
E. O. Nay, M.D.
F. R. N. Carter, M.D.
Paul P. Bailey, M.D.

COMMITTEE ON VETERANS' AFFAIRS AND REHABILITATION

The Veterans Affairs Committee held one scheduled meeting in Indianapolis for the purpose of signing a new contract with the Veterans Administration. It was the opinion of the committee that too many non-service-connected patients were receiving care at veterans hospitals, but other than a protest we had no power for action. No irregularities by the physicians participating, or by the Veterans Administration or by the veterans were referred to our committee during the year.

We plan a luncheon at the fall meeting for general discussions.

Wm. H. Garner, M.D., *Chairman,*
Lester D. Bibler, M.D.,
W. W. Holmes, M.D.,
George K. Hammersley, M.D.,
R. A. Fleetwood, M.D.

THE JOURNAL

I am glad to report to you that the affairs of The Journal during the past twelve months have been successful, both from a financial and editorial point of view.

The scientific content of The Journal is derived from two main sources. One of these consists of original papers which are submitted for publication; the other main source is the collection of papers which are delivered at the Annual Convention.

During the past year we have been favored with an adequate number of scientific articles. The Editorial Board is charged with the review of this material. They have set high but reasonable standards. It is our custom to suggest revisions when it seems advisable, and many of the published papers have been reworked to improve their readability and scientific value.

It is our policy to maintain a backlog of accepted papers only large enough to allow adequate time for the revision, editing and processing of unpublished material. At the present we have accepted papers on hand sufficient for three issues.

Papers which are delivered at the Annual Convention are also published in The Journal. In the past it has been customary to print them all. Our policy now is to select the Convention papers which are especially suitable. Some of the Convention essays are written for the spoken word, and do not make good reading. Others are illustrated profusely with slides and do not make good publications. Some of the best papers have been published previously in almost identical form. For one reason or another approximately half of the Convention papers have been excluded.

The Journal has continued to publish informative articles on socialization of medicine, since it is our view that the medical profession is only well into this controversy, and is far from having it licked.

We have also printed scientific information in regard to the medical aspects of Civil Defense, since this enormous problem presents a real challenge to the profession. The June, 1951 issue was devoted entirely to medical planning for large scale disaster. It has received compliments from many sources within the state and nationally.

As on previous occasions, I would like to take this opportunity to acknowledge and express my thanks for the assistance of all members of The Journal staff, without whose genuine interest, hard work, and sound advice, The Journal could not be published.

Frank B. Ramsey, M.D., *Editor.*

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INDIANA STATE MEDICAL ASSOCIATION
Indianapolis, Indiana

October 29, 30 and 31, 1951

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Benjamin F. Pence, Columbia City	Otto F. Lehmberg, Columbia City

REFERENCE COMMTTEES—1951

1. Sections and Section Work:
Robert H. Rang, Washington (Daviess-Martin), Chairman
E. B. Jewell, Logansport (Cass)
Richard P. Good, Kokomo (Howard)
Clay Ball, Muncie (Delaware-Blackford)
G. M. Nie, Huntington (Huntington)

2. Rules and Order of Business:
Virgil McCarty, Princeton (Gibson), Chairman
G. O. Larson, LaPorte (LaPorte)
William Karsell, Bloomington (Owen-Monroe)
M. C. Topping, Terre Haute (Vigo)
Robert D. Howell, Indianapolis (Marion)

3. Medical Education and Hospitals:
W. C. Wright, Fort Wayne (Allen), Chairman
V. Earle Wiseman, Greencastle (Putnam)
J. R. Nash, Albion (Noble)
R. R. Ploughe, Elwood (Madison)
T. V. Petranoff, Indianapolis (Marion)

4. Public Policy and Legislation:
Harold C. Ochsner, Indianapolis (Marion), Chairman
A. S. Giordano, South Bend (St. Joseph)
R. R. Calvert, Lafayette (Tippecanoe)
Davis W. Ellis, Rushville (Rush)
Truman Caylor, Bluffton (Wells)

5. Publicity:
Ray Elledge, Hammond (Lake), Chairman
Oran A. Province, Franklin (Johnson)
Robert M. Maurer, Brazil (Clay)
W. D. Britton, Montezuma (Parke-Vermillion)
E. E. Shrock, Amboy (Miami)

6. Hygiene and Public Health:
James M. Kirtley, Crawfordsville (Montgomery), Chairman
George Vail, Lawrenceburg (Dearborn-Ohio)
W. B. Lybrook, Indianapolis (Marion)
John S. Hash, Noblesville (Hamilton)
Max Long, Marion (Grant)

7. Amendments to Constitution and By-Laws:
Augustus P. Hauss, New Albany (Floyd), Chairman
J. L. Allen, Greenfield (Hancock)
C. H. McCaskey, Indianapolis (Marion)
I. E. Huckleberry, Salem (Washington)
Roy A. Geider, Indianapolis (Marion)

8. Reports of Officers:
S. J. Petronella, East Chicago (Lake), Chairman
H. P. Ross, Richmond (Wayne-Union)
H. M. Omstead, Petersburg (Pike)
Guy B. Ingwell, Knox (Starke)
Norbert Welch, Vincennes (Knox)

9. Committee on Credentials:
William E. Amy, Corydon (Harrison), Chairman
Clifford H. Jinks, Indianapolis (Marion)
Carl F. Briggs, Sullivan (Sullivan)
W. G. Pippenger, Brook (Jasper-Newton)
George Seward, North Manchester (Wabash)

10. Committee on Miscellaneous Business:
John M. Paris, New Albany (Floyd), Chairman
Lee J. Maris, Attica (Fountain-Warren)
H. T. Combs, Evansville (Vanderburgh)
Martin C. Heck, Jasper (Dubois)
Jack Lockhart, Connersville (Fayette-Franklin)

11. Committee on Prepaid Medical Insurance:
William C. Reed, Bloomington (Owen-Monroe), Chairman
William H. Garner, New Albany (Floyd)
Charles N. Manley, Rising Sun (Dearborn-Ohio)
K. N. Venis, Muncie (Delaware-Blackford)
G. K. Hammersley, Frankfort (Clinton)

COMMITTEES ON CONVENTION ARRANGEMENTS

PUBLICITY: Chairman, Harry Pandolfo; James Young; Robert Hansell; J. W. Wright, Jr.

SMOKER AND STAG: Chairman, Ralph Everly; Vice-Chairman, Loren Martin; Chester Stayton, Jr.; L. J. Clark; Albert Donato.

FINANCE: Chairman, D. S. Megenhardt; Vice-Chairman, John Beeler; Richard Harding.

LANTERN: Chairman, D. J. Caseley; Leroy Burney; J. L. Arbogast.

WOMEN PHYSICIANS: Chairman, Helen Van Vactor; Frances Brown; Olga Bonke-Booher.

GOLF: Chairman, C. B. Fausset; Howard Beaver; Ross Griffith; E. W. Dyar.

FIFTY YEAR CLUB RECEPTION: Chairman, O. S. Jaquith; Oliver Neier; Charles Voyles; A. S. Jaeger; William King.

TRAP SHOOT: Chairman, Louis Need; Myron Nourse; Horace Banks.

ENTERTAINMENT: Chairman, Robert Fry; F. P. Jones; Loren Martin; William Matthews; John Hetherington; John Courtney.

HOUSING: Chairman, J. E. Gillespie.

RECEPTION: Chairman, Earl Mericle; Glen Ryan; Roy Geider; Frank Albertson; Joseph Bean, Rolla Burghard, Thomas Brady, A. Ebner Blatt, Robert Cusack, Marvin Cuthbert, Joseph Dowd, Wendell Brown, Paul Evans, Robert Fullerton, Edward Boyer, Wayne Carson, John Hetherington, Harrison Green, Glenn Irwin, Paul Cullen, Donald J. Caseley, Arthur Jay, David Jones, Walter Kelly, F. P. Jones, O. L. Kirklin, Chet Lamber, L. A. Ensminger, Ralph Leser, Paul Muller, Ottis Olvey, John Eberwein, Irwin Permer, Malcolm Scamahorn, Dwight Schuster, A. M. Hetherington, Paul Iske, Ralph Everly, David Joe Smith.

SCIENTIFIC EXHIBITS

Donald J. Caseley, M.D., Indianapolis, Chairman
Thurman B. Rice, M.D., Indianapolis
John L. Arbogast, M.D., Indianapolis
J. Frank Maurer, M.D., Brazil
C. Toney Dutchess, M.D., Galveston.

Lounge Room, Murat Temple

1. Veterans Administration.

D. R. Adams, M.D., Chief Professional Section Region Office, Indianapolis

More than 1,200 physicians in the state of Indiana, who are members of the participating group under the Indiana State Medical Association Contract, will have the opportunity to see the program of the Veterans Administration for Medical Service on a Fee Basis. Literature will be available for the edification of those association members not participating at this time, who may be interested in applying for the position of a designated examiner.

2. Recent Advances in the Separation and Fractionation of Human Blood and the Storage of Blood and Blood Fractions.

James L. Tullis, M.D., and associates, University Laboratory of Physical Chemistry, Harvard University.

The exhibit will consist of apparatus for the venesection of donors, the collection of donor blood in a bag receptacle, its decalcification during collection by a cation-exchange resin and injection into transfusion recipients. There will also be a display of apparatus for the separation of red cells, white cells and platelets in a closed, air-free, bacteriologically sterile system employing methods of differential separation of the formed elements by mechanical centrifugation and sedimentation.

3. Therapy of Heart Failure.

George F. Schmidt, M.D., Miami, Florida

The four cardinal therapeutic measures used in the treatment of heart failure are presented: (1) digitalis preparations, (2) mercurial diuretics, (3) low sodium diets, and (4) oxygen therapy.

Explanatory literature summarizing the main facts are available for distribution.

4. Display of Special Instruments.

F. E. Hagie, M.D., Richmond

Photographs will be presented showing x-rays which demonstrate the application of special hip pins for the treatment of femoral neck fractures, plates and lag screws for the treatment of intertrochanteric fractures of the femur, plates and lag screws for use in fractures of the surgical neck of the humerus. There will be a display of "T" stacks for hemostats with a mayo table arranged, tyer used in gall bladder surgery, locking, self-retaining retractors for abdominal, bladder and bone work, and other useful instruments.

5. "What's Your H Q"?

Indiana Heart Foundation

Two Heart Quiz boards will be available, one of which will carry questions for members of the medical profession and equipped with a buzzer which signals correct or incorrect answers. The other board will be prepared with answers applicable for the lay public.

The profession is invited to try its skill.

6. Laboratory Services Available to the General Practitioner.

Indiana Association of Clinical Pathologists

Information is presented by maps and diagrams showing the availability of laboratory facilities in the state of Indiana and outlining the arrangements which can be made with the assistance of pathologists to facilitate the performance of common laboratory tests in office practice.

7. Angiography—The Roentgenographic Study of the Heart, the Aorta, and the Great Vessels.

John A. Campbell, M.D., and James P. Lorman, M.D., Department of Radiology, Indiana University School of Medicine

Angiographic study of the heart, aorta and cerebral vessels has come to be an important tool for the physician and, in particular, the radiologist in the diagnosis of vascular anomalies, neoplasms and certain acquired conditions affecting the above structures.

The exhibit consists of reproductions of roentgenograms demonstrating most of the conditions in which angiography is of use.

8. Technique and Results of Operation for Spina Bifida.

William R. Chambers, M.D., South Bend

Ten consecutive unselected cases of meningomyelocele were undertaken for operation. The principle of early operation was employed. The method of operating and the results two to three years later are shown.

9. American Academy of General Practice.

Indiana Chapter of the American Academy of General Practice

The story of the American Academy of General Practice is presented in small panels which depict its origin, growth, organization, and work. Facts are also available concerning the publication of the academy's "GP."

10. Diseases of the Anus, Rectum, and Sigmoid.

Edwin H. Albano, M.D., East Orange, New Jersey

This exhibit will display the newer methods of diagnosis and treatment of diseases of the anus, rectum, and sigmoid. It emphasizes the importance of surgical biopsy, the surface biopsy (Papanicolaou smear) and the sponge biopsy. The technique of each method is described and illustrated. The advantages of the combined procedures are stressed. The exhibit includes a manikin illustrating the various inflammatory and neoplastic lesions of the lower intestinal tract. Gross specimens and microscopic slides are included.

11. A Coding and Cross Index System for Office Practice.

Allen C. Nickel, M.D., and Wallace S. Tirman, M.D.

A practical system for classification and coding of diseases is presented for use by physicians in office practice. The method is simple to use and is not time-consuming. It is based on a system devised by Hadge and Lampe for use in roentgenological diagnosis.

Diseases are grouped into eleven broad fields. Each field is subdivided into thirty etiological headings. A loose-leaf book method is used for filing.

12. Skin Cancer Lesions.

S. R. Mercer, M.D., Ft. Wayne, Indiana

A photographic display is presented of the lesions of skin cancer emphasizing early recognition and demonstrating early signs and symptoms as apparent on physical examination.

13. "You and Your A.M.A."

American Medical Association

A display is presented showing the relationship of the A.M.A. to its members, and the functions, particularly of the Council on Medical Service.

DATA FROM PREVIOUS SESSIONS

Year	Session	Place	Registration
1908	59th	French Lick	312
1909	60th	Terre Haute	421
1910	61st	Fort Wayne	450
1911	62nd	Indianapolis	748
1912	63rd	Indianapolis	590
1913	64th	West Baden	312
1914	65th	Lafayette	527
1915	66th	Indianapolis	646
1916	67th	Fort Wayne	381
1917	68th	Evansville	270
1918	69th	Indianapolis	388
1919	70th	Indianapolis	---
1920	71st	South Bend	421
1921	72nd	Indianapolis	550
1922	73rd	Muncie	522
1923	74th	Terre Haute	823
1924	75th	Indianapolis	1,012
1925	76th	Marion	800
1926	77th	West Baden	900
1927	78th	Indianapolis	1,500
1928	79th	Gary	892
1929	80th	Evansville	814
1930	81st	Fort Wayne	1,115
1931	82nd	Indianapolis	1,033
1932	83rd	Michigan City	904
1933	84th	French Lick	637
1934	85th	Indianapolis	1,814
1935	86th	Gary	1,011
1936	87th	South Bend	1,150
1937	88th	French Lick	1,154
1938	89th	Indianapolis	1,751
1939	90th	Fort Wayne	1,332
1940	91st	French Lick	1,064
1941	92nd	Indianapolis	1,890
1942	93rd	French Lick	706
1943	94th	Indianapolis	1,323
1944	95th	Indianapolis	1,584
1945	96th	French Lick	922
1946	97th	Indianapolis	2,240
1947	98th	French Lick	1,618
1948	99th	Indianapolis	2,681
1949	100th	Indianapolis	3,371
1950	101st	French Lick	1,610

VISIT THE TECHNICAL EXHIBITS AT INDIANAPOLIS

The technical exhibitors at our annual convention contribute a major share of the expense of this meeting. Show your appreciation of their support by utilizing the intermissions which have been arranged in the scientific sessions to visit with them.

TECHNICAL EXHIBITORS

ABBOTT LABORATORIES
NORTH CHICAGO, ILL.

BOOTH 32

The Abbott exhibit will include ABBOCILLIN 800M, offering 800,000 units of penicillin in a 1-cc. vial; SUCARYL, a noncaloric sweetener that can be used in cooking, baking and canning; DAYALETS and OPTILETS, new synthetic multiple vitamin tablets; NEMBUTAL, a short-acting barbiturate, and a number of other specialties.

AKRON SURGICAL HOUSE, INC.
217-223 NORTH PENNSYLVANIA ST.
INDIANAPOLIS 4, IND.

BOOTHS 28 AND 39

The Akron Surgical House, Inc., will exhibit at the annual session of the Indiana State Medical Association October 29, 30, and 31, where we will have an interesting display of instruments and equipment.

THE ALKALOL COMPANY
TAUNTON, MASS.

BOOTH 85

The Alkalol Company, Taunton, Massachusetts, will feature Alkalol, the balanced, alkaline, saline solution for the treatment of mucous membranes and irritated tissues. It is bland, nontoxic, and effective, and has been a favorite since 1896. We are also showing IRRIGOL, a powder which in solution makes an aseptic, slightly astringent vaginal douche. It is widely used also for colonic irrigations and as an effective rectal enema.

A. S. ALOE COMPANY
1831 OLIVE ST., ST. LOUIS 3, MO.

BOOTH 64

Say "Hello" to Kel Howton and Herb Detrick, A. S. Aloe representatives, who will be in Booth 64. They would like to show you our new topical anesthetic "Americaine." You will also be able to see a representative assortment of Aloe instruments, including many of our Government Surplus Specials. Our Scientific Division has sent a Lietz Colorimeter, Spencer HB Meter, Gutta Test, Simplex Centrifuge, and many other items, which will interest all of you —specialist and general practitioner alike.

Herb and Kel are really anxious to meet you. Won't you please drop by?

AMERICAN HOSPITAL SUPPLY CORPORATION
2020 RIDGE AVE., EVANSTON, ILL.

BOOTH 63

American's exhibit offers Baxter intravenous solutions including the new invert sugar (Travert) solution which provides twice the calories in the same infusion time; Baxter blood transfusion and plasma equipment; Acthar, the original ACTH product; Aero-Klenz solution and Gel, a true deodorant; Human Blood Typing and Grouping Serums of high titre; and other Tomac specialties.

AMERICANA CORPORATION
333 N. MICHIGAN AVENUE, CHICAGO 1, ILLINOIS

BOOTH 87

AMES COMPANY, INC.
ELKHART, IND.

BOOTH 44

The Ames DIAGNOSTIC KIT will be featured. This small kit, measuring 3 x 9 inches, contains CLINITEST—a test for urine-sugar; BUMINTEST—a test for albumin; ACETEST—a test for acetone; and HEMATEST—a test for occult blood. No extra reagents, equipment, or accessories are needed. This kit is designed for the physician's office, small laboratory, hospital floor use, etc. The Ames representatives will be demonstrating these tests.

Ames Company representatives will be glad to discuss DECHOLIN and DECHOLIN SODIUM, the standard hydrocholeretic agents for the treatment of biliary tract diseases.

THE ARMOUR LABORATORIES
520 N. MICHIGAN AVE., CHICAGO 11, ILL.

BOOTH 67

The Armour Laboratories will welcome members of the Indiana State Medical Association to visit the Armour Exhibit, Space No. 67, while attending their Annual Convention.

Information on new items in the field of endocrinology, particularly ACTHAR (ACTH), is available to physicians on request; and TRYPTAR—highly purified crystalline trypsin.

AYERST, McKENNA and HARRISON
Limited
22 EAST 40th ST., NEW YORK 16, N. Y.

BOOTH 34

Physicians attending the meeting of the Medical Association of the State of Indiana are cordially invited to visit the Ayerst booth. Our representatives will be happy to answer your inquiries relative to "Premarin," "Premarin" with Methyltestosterone or other Ayerst specialties.

BABY DEVELOPMENT CLINIC
600 S. MICHIGAN AVE., CHICAGO 5, ILL.

BOOTH 9

MATERNITY COUNSELLING SERVICE is a courtesy service available to doctors for their maternity patients. It relieves the doctor of the necessity of discussing layette needs and other preparations for home and baby. There is no charge or obligation to either doctor or patient.

THE BABY DEVELOPMENT CLINIC will feature the psychological aspects of feeding, as well as several products suited to infant and child feeding and care. The manufacturers of these products support the educational work of this organization.

BAKER BROTHERS INC.
233 N. DELAWARE ST., INDIANAPOLIS, IND.

BOOTH 94

Baker Brothers Inc., 233 North Delaware Street, Indianapolis, will have a display of products in Booth 94, adjoining the Scientific Exhibit. The firm sells and maintains complete rental service for sick room supplies, invalid equipment, for home and hospital. Items to be displayed during the Association convention include Hospital Beds—Balkan Frames — Everest and Jennings Folding Wheel Chairs—Oxygen Equipment: including masks, tents and other miscellaneous items. Mr. Ernest E. Daniels, Oxygen Technician, will be in attendance at the Oxygen Service Display. Mr. F. M. Jones, secretary-treasurer of the firm, and Mr. F. C. Jones will be present to acquaint doctors with the complete services offered by Baker Brothers.

THE BAKER LABORATORIES, INC.
4614 PROSPECT AVE., CLEVELAND 3, OHIO

BOOTH 49

Baker's Modified Milk (Liquid and Powder) is made from Grade A Cows' milk, fortified, adjusted and processed to obtain more efficient nutritive action and to insure better tolerance. Baker's has an adjusted protein, two carbohydrates, a modified fat, vitamins, soluble mineral salts and iron coupled with simplicity of preparation and low cost.

BARD-PARKER COMPANY, INC.
DANBURY, CONN.

BOOTH 37

Genuine Bard-Parker "Rib-Back" surgical knife blades, "the blade that assures cutting efficiency." A quality product, that makes for blade economy; B-P handles of various types; Bard-Parker Germicide—a sporicidal solution; Bard-Parker Chlorophenyl; instrument sterilizing containers; The Reese Dermatome—for obtaining accurate split grafts.

BAXTER LABORATORIES, INC.
MORTON GROVE, ILL.

BOOTH 95

The new drug, Pyromen ® is a sterile, nonprotein, nonanaphylactogenic bacterial component in a colloidal dispersion for intravenous or intradermal use. Pyromen produces a generalized stimulation of the reticuloendothelial system and increased adrenocortical activity. Pyromen is a successful new drug which has proved its usefulness in the treatment of allergies and dermatoses.

THE BORDEN COMPANY
350 MADISON AVE., NEW YORK 17, N. Y.

BOOTH 46

Borden representatives will be more than pleased to discuss a new powdered infant food with you. Bremil is a completely modified milk in which nutritionally essential elements of cow's milk have been adjusted to supply the nutritional requirements of infants deprived of human milk. Clinical, x-ray and laboratory evidence with a large group of infants fed exclusively on Bremil proved conclusively its efficacy as an infant food. Bremil is a new phase in infant feeding.

Likewise exhibited will be our long-established products for infant feeding: Biolac, Dryco, Mull-Soy, Merrell-Soule Special Milks, general purpose Klim, and Beta Lactose.

THE BOWMAN BROS. DRUG COMPANY

CANTON, AKRON, and LIMA

BOOTH 4-a

The Bowman Bros. Drug Company, an Ohio corporation, was established at Canton some fifty years ago. From modest beginnings, our present operation is now extended into Pennsylvania, Indiana, West Virginia, and all of Ohio.

Our activities are confined almost exclusively to the field of ethical marketing to allied medical professions. Our main plant is in Canton, Ohio, and we operate branches in Lima and Akron, Ohio, in order to give our customers better service. Our chief pride is in the full line of high grade pharmaceuticals which we manufacture with our own plant facilities. In addition, we can supply surgical and diagnostic instruments and all types of medical furniture that can be found in a physician's office. In fact, we are distributors for all leading houses in our industry.

The best description of our work can be supplied in the phrase—'The service of supply to the Medical Arts.'

BROOKS APPLIANCE COMPANY

5 N. WABASH AVE., CHICAGO, ILL.

BOOTH 45

Quality bandages will be displayed. We shall feature Polyestol, an elastic transparent bandage, which, when applied, releases Methyl Salicylate by absorption into the blood stream at approximate rate of 3.5 mg. per square inch per hour at normal body temperature. Medicated Primer plus Dalzoflex elastic adhesive may be used to advantage in treating leg ulcers and Phlebitis. Mr. Ayer or Mr. Bentley will describe in detail technique of application.

BROWN & WILLIAMSON TOBACCO CORPORATION

1600 W. HILL ST., LOUISVILLE, 1, KY.

BOOTHS 15 AND 80

Members of the Indiana State Medical Association are cordially invited to visit the two booths of the Brown and Williamson Tobacco Corporation. One booth will be devoted to KOOL, mildly mentholated cigarettes; the other to VICEROY, filter tip cigarettes. Both brands are of particular interest to the medical profession. Gifts will be presented to I.S.M.A. members registering at the KOOL and VICEROY booths.

BURROUGHS WELLCOME & CO., INC.

TUCKAHOE, NEW YORK

BOOTH 55

We will feature 'PERAZIL' brand Chlorcyclizine Hydrochloride, the chemically different antihistaminic, distinguished by its long action and low incidence of side effects; the new 'PERAZIL' Cream, a milestone in topical antihistaminic therapy; 'Tabloid' brand DIGOXIN, for precise, predictable digitalization; GLOBIN INSULIN 'B. W. & Co.,' the only official USPXIV insulin with the desirable intermediate timing of action; and 'DEXIN' brand High Dextrin Carbohydrate, the ideal carbohydrate in adult and infant feeding.

CAMEL CIGARETTES
ONE PERSHING SQUARE
NEW YORK 17, N. Y.

BOOTH 23

CAMEL Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking CAMEL Cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking CAMELS."

S. H. CAMP AND COMPANY
JACKSON, MICHIGAN

BOOTH 27

S. H. Camp & Company, Jackson, Michigan, will display a complete line of Camp Anatomical Supports for prenatal, postnatal, visceroptosis, sacro-iliac, hernia, and other specific conditions. Experts from the Camp staff will be in attendance to answer questions pertaining to the scientific application of these supports and to advise regarding the availability of them in authorized service departments of stores throughout the country.

THE CENTRAL PHARMACAL COMPANY
SEYMOUR, INDIANA

BOOTH 35

Members of the Indiana State Medical Association and their guests will enjoy an enthusiastic welcome at the Central display booth.

Our Synophylate line will be featured in all dosage forms; ampuls, suppositories, syrup and tablets.

Synophylate, or Theophylline-Sodium Glycinate, is the superior Theophylline compound for the improved treatment of asthmatic and cardiac conditions. Higher Theophylline blood levels may be obtained with Synophylate, and undesirable side actions avoided.

THE CHICAGO DIETETIC SUPPLY HOUSE
Incorporated
1748-52 W. VAN BUREN ST., CHICAGO 12, ILL.

BOOTH 16

You are cordially invited to visit our display of CELLU Dietetic Products for use in **Low Sodium, Allergy** and **Sugar and Starch Restricted Diets.** Many products will be featured for each type of diet along with new descriptive catalogs and recipe books.

CHICAGO PHARMACAL COMPANY
Pharmaceutical Chemists
5547 N. RAVENSWOOD AVE., CHICAGO, ILL.

BOOTH 62

The Chicago Pharmacal Company exhibit features a most comprehensive, up-to-date catalogue describing in detail one of the most complete high quality pharmaceutical lines. Emphasis is on Chimedic Diethylstilbestrol, U.S.P., Alpha-Estradiol, U.S.P., Calcium Levulinate, U.S.P., Digitoxin, U.S.P., and many Chimedic specialties. The service features and complete therapeutic index in the catalogue offer to the Medical Profession a thorough description of the Chimedic line ably presented by our Indiana veterans, Mr. Cole of Peru, and Mr. Willis of Clermont.

CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT, NEW JERSEY

BOOTH 33

Ciba Pharmaceutical Products, Inc., Summit, New Jersey invites you to visit its exhibit, which will feature "24-hour relief of allergy" with PYRIBENZAMINE Hydrochloride.

Representatives in attendance will gladly discuss the roll of PYRIBENZAMINE in the treatment of various forms of allergy.

THE COCA-COLA COMPANY
ATLANTA, GA.

BOOTH 90

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company, Indianapolis, Inc., and The Coca-Cola Company.

COMMERCIAL SOLVENTS CORPORATION
17 E. FORTY-SECOND ST., NEW YORK 17, N. Y.

BOOTH 73

"CSC" Pharmaceuticals will feature Tolanate—a newly available organic nitrate for the management of hypertension, and bacitracin in a variety of dosage forms. Tolanate makes available for clinical use the blood pressure-reducing influence of inositol hexanitrate. This organic nitrate is of the long-acting type, the use of which leads to sustained control of the blood pressure. Also available is Tolanate with Phenobarbital. Tolanate offers the advantages of lower dosage, prolonged action and virtual absence of "Nitrite Headache."

CURTIS & FRENCH, INC.
1108 N. PENN. ST., INDIANAPOLIS 2, IND.

BOOTHS 91 AND 92

Jack Curtis, Mac McCain, Bob Ettinger, Jim Traub and Tom Sternburgh will be on hand to welcome all of our old and new friends. New equipment of interest to all will be displayed.

DAIRY COUNCILS OF INDIANA
155 E. MARKET ST., INDIANAPOLIS, IND.

BOOTH 70

You are invited to visit our booth for a cold, refreshing drink of milk. Dairy Council health education materials will be on display. These materials are free of charge in the localities which have affiliated units.

The exhibit is sponsored by the Dairy Councils of Evansville, Fort Wayne, Indianapolis and South Bend. These units are affiliated with the National Dairy Council of Chicago, which is the health education organization of the dairy industry.

DICK X-RAY COMPANY, INC.
443 N. PENN. ST., INDIANAPOLIS, AND
3976 OLIVE ST., ST. LOUIS, MO.

BOOTH 31

The Dick X-ray Company will have on display: Westinghouse X-Ray Equipment—Liebel-Flarsheim Short Wave Machines—Cambridge "Simpli-trol" Portable Electro-cardiograph — Fluorescent Viewers — Physiotherapy Equipment.

DOHO CHEMICAL CORPORATION
100 VARICK ST., NEW YORK 13, N. Y.

BOOTH 71

Doho Chemical Corporation and its subsidiary, Mallon Chemical Corporation, are pleased to exhibit their preparations AURALGAN for the relief of pain in Otitis Media and removal of Cerumen: New: O-**TOS**-MO-SAN for treatment of the suppurative ears and aural dermatomycosis: RHINALGAN the new nasal decongestant without systemic or circulatory effect, in the plastic spray-o-mizer, and RECTALGAN (MALLON) the liquid topical anesthesia, for relief of pain and discomfort in hemorrhoids, pruritus and perineal suturing.

EDISON CLINICAL RECORDING
VAN AUSDALL & FARRAR
7 WEST 10TH ST., INDIANAPOLIS

BOOTH 22

MEDICAL RECORDS by EDISON **TELEVOICE**

Convenient TeleVoice phones in the large or small hospital or physician's office invite immediate, effortless, and rapid recording of all parts of the clinical record.

It's easy, too! Doctors have no levers, discs, cylinlers, or instruction slips to worry about. Just pick up an Edison phone and talk away the records, that's all!

Your librarians and medical stenographers will be grateful for this system, too. It assures legible, accurate, detailed, typewritten medical records.

Your patients will be grateful for the time Edison TeleVoice saves you, for through saving your time better service can be assured.

You will benefit by Edison's experience. Years of research and actual hospital use have proved that this system clearly answers the problem of producing accurate medical records.

All this can be obtained with savings up to 66 percent less than cost of any system known prior to TeleVoice.

C. B. FLEET CO.
Incorporated
924-927 COMMERCE ST., LYNCHBURG, VA.

BOOTH 86

C. B. Fleet Company, Inc., cordially invites you to stop at Booth 86 to see the exhibit of Phospho-Soda (Fleet). Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 gm. and sodium phosphate 18 gm.

Phospho-Soda (Fleet) over the years has won discriminating preference by thousands of physicians—because of its controlled action, its freedom from undesirable side effects, and its ease of administration.

There is only ONE Phospho-Soda (Fleet).

FREEMAN X-RAY CO.
4528 W. LAWRENCE AVE., CHICAGO 30, ILL.

BOOTH 4-D

Booth No. 4-D, Freeman X-Ray Company, Chicago, Illinois, exclusive distributors of Mattern X-Ray Apparatus, will exhibit the new Mattern Model "MR" Royal 100, combination fluoroscopic and radiographic tilt table x-ray unit. This new unit incorporates such features as the automatic push button control, electronic timer, finger tip hand tilt table, bucky diaphragm, oil immersed double focus shockproof x-ray tube. Hospital type tubestand with all safety devices and new features. The inexperienced technician can produce outstanding radiographs with this new unit. Beautifully finished in a new startling royal blue metallic finish. 30-60-100 or 200 Milliampere capacity.

GENERAL ELECTRIC X-RAY CORPORATION
4855 ELECTRIC AVENUE,
MILWAUKEE 14, WISCONSIN
306 CHAMBER OF COMMERCE BUILDING,
INDIANAPOLIS 4, INDIANA

BOOTH 59

GERBER PRODUCTS COMPANY
FREMONT, MICHIGAN

BOOTH 19

Gerber's four one-grain cereals are "on sale" in nearly all stores. The new, important RICE CEREAL is supplemented with selected cortical portions of the rice grain naturally rich in vitamin B-complex. Enriched also with iron and calcium, the finished precooked cereal more than represents whole-grain rice in nutritional values.

J. E. HANGER, INC.
1407 N. ILLINOIS ST., INDIANAPOLIS 2, IND.

BOOTH 40

J. E. Hanger, Incorporated, manufacturers of prosthetic appliances, wish to invite you to visit our exhibit, to see and discuss the various types of artificial appliances. We are happy to announce that the Vacuum Socket limb has passed the experimental stage and has become very popular with both the Veterans Administration and the general public.

Our company wishes to express its thanks for your past consideration and cooperation. We will continue to give you the best possible service as we have always endeavored to do in the past.

H. J. HEINZ COMPANY
PITTSBURGH 30, PA.

BOOTH 68

Stop at the Heinz exhibit for these: Nutritional Data, Nutritional Observatory. Do you need Baby Gift Folders for distribution among your patients? Have you seen the additions to Heinz Baby Food line—Strained Pears and Pineapple and Strained Sweet Potatoes? New Junior foods are Pears, Pineapple, Custard Pudding, Chicken Soup, Vegetable Soup, Green Beans, Carrots, and Butterscotch and Chocolate Puddings.

HOFFMANN-LA ROCHE, INC.

ROCHE PARK, NUTLEY 10, NEW JERSEY

BOOTH 30

Two new drugs are featured in the Roche display: ASTEROL for ringworm; and GANTRISIN OPHTHALMIC for eye infections.

ASTEROL is a new, **odorless,** nonstaining drug for "athlete's foot" and other ringworm infections. It provides potent antifungal action combined with mild keratolytic activity in ringworm of the skin, hair and nails. Because it is clean to use and well tolerated, it is readily acceptable for external application to all parts of the body including the scalp, the groin, the hands and the feet.

GANTRISIN OPHTHALMIC is a new, stable, nonirritating sulfonamide solution for external eye infections. Because the solution is isotonic and the pH is physiological, it seldom causes stinging or burning in the inflamed eye. Furthermore, the solution is stable and requires no refrigeration and subsequent warming before use.

Won't you visit with us at the Roche booth? We will be glad to be of service in every way possible.

HOLLAND-RANTOS COMPANY, INC.

NEW YORK, N. Y.

BOOTH 54

Koromex Combination Sets — designed to meet varying requirements for **dependable** conception control—will be featured in the display of time-tested Koromex Diaphragms, Jelly, Cream and supplementary items. Physicians are cordially invited to visit the H-R exhibit, inspect the full line of well-known H-R products, as well as new items of particular value in your own practice.

THE HOOSIER CASUALTY COMPANY

OF INDIANAPOLIS

BOOTH 93

1. There will be available complete information of general interest on our plan of Comprehensive Disability Insurance Protection for members of the medical profession, including our experience with the largest single group in the state—The Indianapolis Medical Society Group.

2. There will be available information on the procedure of the Indianapolis Hospital Admissions Plan effective as of September 4, 1951, and how our direct on-the-spot Home Office service can be utilized for the greatest satisfaction of all concerned.

3. There will be available complete information on "Your Local Agents Plan." This is a Comprehensive plan of Hospitalization, Surgical, Medical Care, Living Expense, and Accidental Death coverage, for the family is sold only through licensed local agents. Surgeons will like the idea of a miscellaneous expense allowance in addition to surgical expense where surgery is performed in office or clinic. General practitioners will be interested in the Medical Care.

C. B. KENDALL COMPANY

2039 MADISON AVE., INDIANAPOLIS 6, IND.

BOOTHS 7 AND 8

The C. B. Kendall Company extends cordial greetings to all the physicians attending the Indiana State Medical Association Convention. You are invited to visit our technical exhibit. Members from our detail staff will be on hand to visit with you and to discuss products which are currently being detailed to the medical profession.

LANTEEN MEDICAL LABORATORIES, INC.

2020 GREENWOOD ST., EVANSTON, ILL.

BOOTH 21

LANTEEN MEDICAL LABORATORIES, INC., extend a cordial invitation to visit their Booth No. 21. Representatives will discuss the improved LANTEEN technique, a dual method of contraception based on the use of the LANTEEN FLAT SPRING DIAPHRAGM and LANTEEN spermatocidal JELLY.

Two new ethical pharmaceuticals are also being featured: ALKAGEL, and VODINE. Samples and literature describing each of these products are available.

LEDERLE LABORATORIES DIVISION

AMERICAN CYANAMID COMPANY

30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

BOOTH 47

You are cordially invited to visit our exhibit in Booth No. 47, where you will find representatives who are prepared to give you the latest information on Lederle products.

ELI LILLY AND COMPANY

INDIANAPOLIS 6, INDIANA

BOOTH 58

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in Space No. 58. In commemoration of the seventy-fifth anniversary of its founding, Eli Lilly and Company will display a statuary group dedicated to and sympolizing the cooperation between medicine, research, and pharmacy. Many new therapeutic developments will be featured and literature on these products will be available.

LINCOLN LABORATORIES, INC.

BOX 1139, DECATUR, ILLINOIS

BOOTH 89

J. B. LIPPINCOTT COMPANY

EAST WASHINGTON SQUARE, PHILADELPHIA 5

BOOTH 51

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

M & R LABORATORIES
COLUMBUS, OHIO

BOOTH 41

Our representatives will appreciate the opportunity to discuss with you the merits and use of our products, Similac and Cerevim, in the field of infant and child nutrition.

MANHATTAN UNIFORM COMPANY
509 S. WABASH AVE., CHICAGO 5, ILL.

BOOTH 78

I saw a newly designed garment which you can wear over your shirt collar and tie or without, and can be fully fastened. It is a collarless type and built up in front high enough to be worn without your shirt if you so elect. The back of collar is high as a regular coat collar and will not cut neck when worn without shirt. It is made with an action back to allow, if necessary, the extra room in back.

There are many other styles of garments for the profession as well as many styles of nurse's uniforms on display.

THE S. E. MASSENGILL COMPANY
BRISTOL, TENNESSEE

BOOTH 50

The S. E. Massengill Company invites you to visit Booth No. 50 where several new Specialty Products are on display. Included in these Specialty Products are Tablets Obedrin and Tablets Khelisem.

Tablets Obedrin and the 60-10-70 Diet represent a new approach in the treatment of obesity. Special diet pads and descriptive literature are available on the new Obedrin Tablets. Khelisem (Massengill brand of visammin) is the enteric-coated pure crystalline khellin; indicated in the treatment of angina pectoris and asthma. Representatives will be glad to discuss these and other products with you at the Massengill exhibit.

MEAD JOHNSON & COMPANY
EVANSVILLE 21, IND.

BOOTH 56

Mead Johnson & Company, Evansville, Indiana (Booth 56) will feature Lactum and Dalactum, convenient formulas of evaporated milk containing Dextri-Maltose; three water soluble multiple vitamin preparations, Mulcin, Poly-Vi-Sol and Tri-Vi-Sol; Fer-In-Sol, a concentrated solution of ferrous sulfate. Also the four Pablum Cereals, including Rice and Barley Cereals, will be on display.

Representatives in attendance will be glad to furnish information regarding the above products.

MEDCO PRODUCTS COMPANY
3603 E. ADMIRAL PLACE, TULSA 12, OKLAHOMA

BOOTH 81

THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, IND.

BOOTH 29

Specializing Exclusively in Professional Protection since 1899, The Medical Protective Company provides representation at Booth 29 familiar with all the complexities of professional liability by special training and long experience. An answer to your problems in the Doctor-Patient relationship is yours for the asking.

MILLER SURGICAL COMPANY
2449 N. PULASKI RD., CHICAGO 39, ILL.

BOOTH 88

Electrically Illuminated Gorsch and Miller Rectal Scopes, Rectal Snares, Smoke Ejectors, Coagulators. Miller Electro-Scalpel and Cautery. Headlites, Reflecting, etc. Miller Ophthalmoscope and complete line of Illuminated and Magnifying Surgical Diagnostic Units.

THE C. V. MOSBY COMPANY
3207 WASHINGTON BLVD., ST. LOUIS 3, MO.

BOOTH 76

MUTUAL MEDICAL INSURANCE, INC.
(The Blue Shield Plan)
500 TERMINAL BUILDING, INDIANAPOLIS

BOOTH 53

Mutual Medical Insurance, Inc. (Blue Shield Plan) will have its exhibit in Booth No. 53.

Representatives of the Plan will be on hand at all times to answer questions and be helpful in any way possible. Special materials will be distributed explaining the operation of the Plan, the benefits it affords the physician and the public, and showing the growth of the Plan in membership during the past five years.

Dr. Walter U. Kennedy, New Castle, is president of the Blue Shield Plan; Dr. W. Harry Howard, Hammond, is vice-president; Dr. Walter L. Portteus, Franklin, is secretary; and Dr. A. F. Weyerbacher, Indianapolis, treasurer.

Administration of The Blue Shield Plan is under the direction of R. S. Saylor, Executive Vice-President, 500 Terminal Building, Indianapolis.

MAURICE NATENBERG
Publisher's Representative
912 GORDON TERRACE, CHICAGO 13, ILL.

BOOTH 72

Mr. Natenberg represents a group of well-known publishers, among them the Year Book Publishers, Grune & Stratton, Inc., Williams and Wilkins, Oxford University Press. Some classics of medical literature will be on display covering every branch of medical science. In addition, there are forthcoming books due for fall and winter publication which will be of great interest; among these are the HANDBOOKS OF OPERATIVE SURGERY, an innovation in surgical literature which is being sponsored by the YEAR BOOK PUBLISHERS.

THE NATIONAL DRUG COMPANY
PHILADELPHIA

BOOTH 17

The National Drug Company, pioneer in the clinical application of resin therapy, will feature NATRINIL, a cation exchange resin for the control of edema; RESINAT, a polyamine exchange resin for the treatment of peptic ulcer; and RESION, an intestinal adsorbent. Trained representatives will be in attendance to discuss our resin preparations and other specialties: Ammivin, AVC Improved, Benat, DTP Vaccine, Natolone, as well as many of National's vast array of pharmaceutical and biological products.

NEPERA CHEMICAL CO., INC.
NEPERA PARK, YONKERS 2, N. Y.

BOOTH 66

The Nepera display is devoted to two council-accepted products—Mandelamine for urinary antisepsis in such indications as cystitis, pyelitis and prostatitis; and Neohetramine, an antihistaminic agent which authorities declare to be notably low in side effects.

THE NESTLÉ COMPANY, INC.
COLORADO SPRINGS, COLO.

BOOTH 61

You are cordially invited to visit Nestlé's Booth No. 61, where specially qualified representatives will be on hand to answer your questions on any of Nestlé's milk products—already best known and most used for babies 'round the world. New pieces of valuable professional literature will be available.

ORTHO PRODUCTS, INC.
RARITAN, NEW JERSEY

BOOTH 74

ORTHO cordially invites you to visit their exhibit at Booth No. 74. The complete line of ORTHO gynecic pharmaceuticals will be featured, including ORTHO-GYNOL, ORTHO-CREME, and the new ORTHO-WHITE Diaphragm.

Also on display will be MASSE' Nipple Cream for the treatment and prophylaxis of cracked nipples, and DIFFUSIN, the ORTHO brand of hyaluronidase. ORTHO representatives will be on hand to greet you.

PARKE, DAVIS & COMPANY
DETROIT 32, MICHIGAN

BOOTH 2

Medical Service Members of the PARKE, DAVIS & COMPANY Staff will be in daily attendance at our Commercial Exhibit for consultation and discussion of the various Products listed in our Pharmaceutic, Antibiotic, and Biologic Catalog. Important Specialties, such as Chloromycetin, Penicillin S-R, Benadryl, Vitamins, Oxycel, Thrombin Topical, Influenza Virus Vaccine, and others will be featured. You are most cordially invited to visit our Exhibit with the assurance that your personal interest will indeed be very much appreciated.

THE PELTON & CRANE COMPANY
632-652 HARPER AVENUE, DETROIT 2, MICHIGAN

BOOTH 84

HOSPITAL SPEED and SAFETY
For the PRIVATE OFFICE

The new Pelton FL-2 Autoclave reduces minutes to seconds between consecutive sterilizing periods. Applying the principles of steam-heated hospital sterilizers, the FL-2 Autoclave brings to the private office a self-contained unit which produces and then stores steam under pressure ready for instant use in the sterilizing chamber. Time between consecutive sterilizing periods is now reduced, from many minutes, to less than 30 seconds. This means no more waiting periods for the necessary temperature and pressure . . . no more wasted time . . . no more watching gauges.

PET MILK COMPANY
1401 ARCADE BLDG., ST. LOUIS 1, MO.

BOOTHS 10 AND 11

A miniature working model of an evaporated milk plant will be exhibited by Pet Milk Company. This exhibit offers an opportunity to obtain information about the production of Pet Milk, its use in infant feeding, and the time-saving Pet Milk services available to physicians. Miniature Pet Milk cans will be given to the physicians who visit the Pet Milk Booth.

CHAS. PFIZER & CO., INC.
630 FLUSHING AVE., BROOKLYN 6, N. Y.

BOOTH 4-B

Terramycin, newest of the broad-spectrum antibiotics, forms a dramatic central feature of the display of Chas. Pfizer & Co., Inc., Brooklyn, N. Y. The newest dosage forms of Terramycin are exhibited and indications for use are described. Specialty forms of both Penicillin and Streptomycin will also be shown.

PHILIP MORRIS & COMPANY, LTD., INC.
100 PARK AVE., NEW YORK, N. Y.

BOOTH 65

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

PITMAN-MOORE COMPANY
Division of Allied Laboratories, Inc.
INDIANAPOLIS 6, IND.

BOOTH 48

Pitman-Moore Company will feature a display of several of its leading specialty products, both pharmaceuticals and biologicals, at its booth at the annual meeting. The exhibit will be under the direction of Mr. Lester E. Davis, Central Regional Manager, who extends a hearty invitation to all members and friends of the Indiana State Medical Association to visit the Pitman-Moore exhibit during the meeting.

PROFESSIONAL CREDIT PROTECTIVE BUREAU
MINNEAPOLIS 1, MINNESOTA

BOOTH 83

The Professional Credit Protective Bureau (division of the I. C. System) is a collection service employing a free credit control plan. We emphasize that this is a service and not a collection agency as all monies are paid directly to the creditor while we do all the work. The rates for collection are amazingly low. This system is sponsored by five leading Indiana trade associations and over sixty trade associations in various fields from coast to coast. Among the more recent sponsors of the Professional Credit Protective Bureau is the North Dakota Dental Association. Mr. Herbert Jerome and Mr. Earl Jolly will gladly explain the program without obligation.

REX TYPEWRITER EXCHANGE
207 MASSACHUSETTS AVE., INDIANAPOLIS, IND.

BOOTH 82

Be sure to visit the Rex Typewriter Exchange Booth. We will have on display all the latest models of Webster Chicago Wire Recorders and Tape Recorders. See the new Model 228 Dictation wire recorder, with push to talk microphone, two-way foot control with back spacer, and other new features. Also see the new Model 210 Tape Recorder that records up to two hours, and has fast forward and fast reverse speeds for your convenience. The new model 228 Wire Recorder will fit all your dictating and transcribing needs at a very low cost. Stop in and have your voice recorded and learn what a time-saver one of these machines can be in your office. Curt Benner will have charge of the display.

RICKRICH SURGICAL SUPPLY COMPANY
801-803 W. INDIANA ST., EVANSVILLE 10, IND.

BOOTH 3

A cordial invitation is extended all physicians to visit our exhibit in Booth No. 3.

George F. Carter, John Stephens and I. J. Rickrich will be there to greet you.

A. H. ROBINS COMPANY, INC.
1711 ELLEN ROAD, RICHMOND 20, VIRGINIA

BOOTH 5

THE W. H. RODEBECK COMPANY
15 E. MARYLAND ST., INDIANAPOLIS 4, IND.

BOOTH 4-C

Steno Dictating Unit 'Ideal' for Doctors

Professional men of Indiana have shown considerable interest in the new steno dictating-transcribing equipment. The Steno machine will be on display at the forthcoming Indiana State Medical Association Convention.

The Steno is ideal for physicians, because technical medical terms are transcribed clearly and the unit is easy to operate. The machine enables a doctor to make recordings from the patient's view. This feature is especially valuable in making subjective examinations, or recording case histories and clinical findings. Most outstanding of Steno features is the fact that only one basic unit is needed. The dictation unit is transformed into a transcriber by merely pushing a button. A doctor's day is rushed. He cannot take time to fuss with mechanical gadgets. Steno is ready to do whatever you ask it to do by simply pushing a button. Every action is automatically controlled.

The W. H. Rodebeck Company, 15 East Maryland Street, Indianapolis, Indiana, is the State distributor for Steno equipment.

SANDOZ PHARMACEUTICALS
Division of Sandoz Chemical Works, Inc.
68-72 CHARLTON ST., NEW YORK 14, N. Y.

BOOTH 14

It is with a great deal of pleasure and pride that we invite you to visit our scientific exhibit, which will feature:

(1) The Disturbances of the Autonomic Nervous System

(2) Vascular Headaches—Mechanism, Diagnosis and Treatment

(3) The Management of Postpartum Hemorrhage

Our representative in this area, Mr. R. N. Pitts, will gladly welcome you at our Booth No. 14.

W. B. SAUNDERS COMPANY
W. WASHINGTON SQUARE, PHILADELPHIA 5, PA.

BOOTH 36

We invite all doctors attending the meeting of the Indiana State Medical Association to visit our exhibit where our representative, Mr. Frank A. McMahon, will display a complete line of our books including Hyman's "Integrated Practice of Medicine," Hyman's "Progress Volume," Conn's "1951 Current Therapy," Alvarez' "The Neuroses," Shanks & Kerley's "Textbook of X-Ray Diagnosis," Braasch & Emmett's "Clinical Urography," Campbell's "Clinical Pediatric Urology," "Surgical Practice of the Lahey Clinic," (new 22nd edition) "The American Illustrated Medical Dictionary," Cecil-Loeb's (new 8th edition) "Textbook of Medicine," Duncan's "Diabetes Mellitus," Levine's (new 4th edition) "Clinical Heart Disease," Greenhill-DeLee's (new 10th edition) "Principles and Practice of Obstetrics," Moore's (new 2nd edition) "Textbook of Pathology," Meschan's "Atlas of Normal Radiographic Anatomy," Sandweiss' "Peptic Ulcer," Cecil's "The Specialities in General Practice," Krusen's "Physical Medicine and Rehabilitation for the Clinician," and many other new books and new editions.

SCHERING CORPORATION
2 BROAD ST., BLOOMFIELD, N. J.

BOOTH 24

Exhibited at the Schering booth will be Tricombisul liquid and tablets—the safest and most desirable forms of sulfonamide therapy; along with Trimetose, an elegant antihistamine expectorant, containing 7.5 mg. of Trimeton per 4 cc., and Coricidin, for the common cold, containing Chlor-Trimeton, aspirin, phenacetin and caffeine.

Schering Professional Service Representatives will be in attendance to welcome you and to discuss these and other Schering products.

G. D. SEARLE & CO.
CHICAGO, ILL.

BOOTH 1

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarling Searle Products of Research.

Featured will be Banthine, the true anticholinergic drug for the treatment of peptic ulcers; Dramamine, for the prevention and active treatment of motion sickness; and Alidase, Searle brand of hyaluronidase, which permits subcutaneous feedings at intravenous speed.

Other time proven products of Searle Research on which information may be obtained are Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine, and Pavatrine with Phenobarbital.

SEVEN-UP BOTTLING COMPANY
INDIANAPOLIS

BOOTH 13

SHARP & DOHME
PHILADELPHIA 1, PA.

BOOTH 75

Clinical data from the laboratories of the Medical Research Division of Sharp & Dohme are featured in Booth No. 75. The potentiating effect of a combination of the antibiotics, bacitracin and tyrothricin; the synergistic effect of penicillin in conjunction with the sulfonamides; and the use of Blood Group Specific substances A and B in conditioning Group O blood, are of major interest.

SMITH-DORSEY
LINCOLN, NEBRASKA

BOOTH 60

Smith-Dorsey cordially invites you to make their booth your headquarters where several new releases are featured:

1. Neutrazyme Suppositories—a new therapy for Idiopathic Pruritus Ani.
2. Neutraphylline—a buffered Aminophylline Suppository.
3. Pabirin—an improved product for Salicylate Therapy.
4. Vagisol Tablets—the modern therapy for Trichomonas Infections.
5. Also featured are many new Injectable preparations.

SMITH, KLINE & FRENCH LABORATORIES
1530 SPRING GARDEN ST.
PHILADELPHIA 1, PA.

BOOTH 77

'Resodec' is a revolutionary new development in the management of congestive heart failure. This remarkable substance produces the effect of cutting the patient's salt intake approximately in half. It does this by removing sodium from the contents of the intestinal tract and carrying it out of the body in the feces.

Thus, 'Resodec' not only gives you a positive means of achieving **adequate** sodium control . . . but also frequently allows your patients greater leeway in selecting foods.

SPENCER, INCORPORATED
NEW HAVEN, CONNECTICUT

BOOTH 18

The Doctor is invited to see Spencer Supports for abdomen, back and breasts—**individually designed to order** to meet the medical needs of the patient.

Featured will be a lightweight, flexible Spencer for maternity wear, which provides constant, nonelastic support of the lower abdomen with no constriction of upper abdomen—especially recommended for the young, active patient.

Spencer's new tubular Orthopedic Shoulder Straps, for providing added effectiveness and **comfort,** will also be shown.

E. R. SQUIBB & SONS
SQUIBB BLDG., 745 5TH AVE., NEW YORK 22, N. Y.

BOOTH 43

Visual Aids Service will be featured by Squibb at the sessions of the Indiana State Medical Association. This service comprises a comprehensive assortment of technical leaflets, practical aids, and descriptive catalogues of films from the Squibb Medical Film Library. You are welcome at the Squibb Booth.

SWIFT & COMPANY
UNION STOCK YARDS, CHICAGO 9, ILL.

BOOTH 28

LIVER & BACON—a new addition to the original line of **all-meat** baby foods, Swift's Meats for Babies & Juniors will be featured at the Swift exhibit. This brings the varieties of Strained and Chopped Meats offered in the Swift line to 7. You are cordially invited to discuss the use of these high-protein, body-building foods in the infant diet with the Swift representatives—also their rapidly growing use in adult special diets. Literature and information on clinical research available.

U. S. STANDARD PRODUCTS CO.
WOODWORTH, WISCONSIN

BOOTH 79

Our general theme will be on the newer advancements in "Lipotropic therapy." Stop by for your LOW FAT—LOW Cholesterol diet lists at no charge to you.

Our representatives, L. F. Haefling, E. H. Hinkebein, Jr., Milt Reisman, and William (Bill) Snider, as well as A. E. Zornig, Sales Manager, will be on hand to meet old friends.

U. S. VITAMIN CORPORATION

250 E. 43rd STREET, NEW YORK 17, N. Y.

BOOTH 42

See and taste for yourself the new and different sodium-free salt substitute—CO-SALT—which actually tastes like salt, looks like salt and sprinkles like salt . . . a great boon to your patients on restricted sodium intake.

Exhibit also features original, complete lipotropic therapy . . . METHISCHOL . . . combination of five proven lipotropic agents: B_{12}, choline, methionine, inositol and liver extract. Therapeutically effective in the treatment of hypercholesterolemia as associated with atherosclerosis, coronary disease, obesity, diabetes and various forms of liver disease, including liver cirrhosis and toxic hepatitis.

THE UPJOHN COMPANY

KALAMAZOO

BOOTH 52

VAISEY-BRISTOL SHOE COMPANY, INC.

ROCHESTER 3, N. Y.

BOOTH 26

The Vaisey-Bristol Shoe Co. exhibit will feature its Jumping Jack shoes for small children. The appearance is somewhat different from the conventional shoe as they feature a sole which continues up the back. This gives the Jumping Jack a cylinder-rounded back which provides a straight line striking point on a curved plane and this tends to make the foot go forward straight, the same as a cylinder lying on its side goes straight when it is rolled. Furthermore, this method of construction makes it possible to fit the curve of the os calcis with a curve.

Jumping Jacks are also characterized by a flexibility allowing the foot almost complete freedom to exercise, with all the muscle building tendencies this implies. The sole is sufficiently heavy to give adequate protection against stones and other sharp objects. The wearing qualities of Jumping Jacks are exceptional as they are usually outgrown before being outworn.

THE WARREN-TEED PRODUCTS COMPANY

582 W. GOODALE ST., COLUMBUS 8, OHIO

BOOTH 25

The Warren-Teed Products Company extends a cordial invitation to visit Booth Number 25 where trained professional service representatives will be on hand to discuss the latest therapeutic contributions made available to the profession. Featured will be ANACOL COUGH SYRUP, an unusually effective and palatable antitussive, and HYCIDARON, which represents a new contribution for the treatment of chronic or refractory hypochromic anemia.

WHITE LABORATORIES, INC.

NEWARK, N. J.

BOOTH 57

GITALIGIN—which has been described as a " . . . digitalis preparation of choice"—will be on display at Booth No. 57. Courteous Medical Service Representatives will appreciate the opportunity to discuss with you the clinical background and therapeutic merit of this and other outstanding White's products.

WILSON MILK CO.

728 CHAMBER OF COMMERCE BLDG.

INDIANAPOLIS, IND.

BOOTH 4

Doctors attending the convention undoubtedly will be interested in the Terminal Heating Sterilizer exhibited by the Wilson Milk Co. and offered as a special service to all new mothers.

This high quality aluminum sterilizer is available at greatly reduced cost on a special offer. Any new mother, regardless of her financial status, can take advantage of the new, safe, advanced Terminal Heating Technique of sterilizing the baby's formula. For simplicity-with-safety, Terminal Heating is now used exclusively in many hospitals and is acclaimed by doctors generally. By supplying this sterilizer at actual cost, this efficient home unit assures continuance of hospital "Formula Kitchen" technique right into the home.

Wilson's Evaporated Milk has long been a favorite in Indiana, among doctors and nurses as well as mothers. It meets all general requirements for infant feeding. It has 400 extra USP units of pure Vitamin D, is sterilized and homogenized, and carries the Seal of Acceptance of the Council on Foods of the American Medical Association.

WINTHROP-STEARNS, INC.

1450 BROADWAY, NEW YORK 18, N. Y.

BOOTH 20

WINTHROP-STEARNS, INC., New York, extends a cordial invitation to visit Booth No. 20, where representatives will be on hand to discuss the latest therapeutic contributions (or pharmaceutical preparations) made by this firm. Featured will be Mucilose Compound Tablets, the new physiologic bulk laxative. Levophed, the true vasoconstrictor hormone of the Adrenal Medulla, for the maintenance of blood pressure in shock and other acute hypotensive states. Milibis, new virtually nontoxic amebacide. Aralen, the modern colorless antimalarial specific.

WYETH, INCORPORATED

PHILADELPHIA

BOOTH 69

News Notes

The Indiana Heart Foundation will hold its Annual Meeting on October 28, at 2:00 P.M., in the Rice Auditorium, State Board of Health Building. The Sunday afternoon meeting just precedes the State Medical Association Meeting, and the Executive Committee of the Indiana Heart Foundation extends a cordial invitation to all doctors, their families and friends to attend.

The Interim Session of the American College of Chest Physicians will be held at the Ambassador Hotel, Los Angeles, on December 2 and 3, 1951. On Sunday, December 2, a scientific session will be presented sponsored by the California Chapter of the College, including round table luncheon discussions and an x-ray conference. A banquet will be held in the evening. The Board of Regents of the American College of Chest Physicians will meet on Monday, December 3, as well as various councils and committees of the College.

A revised list of "Sources of Motion Pictures on Health" has been prepared by the Committee on Medical Motion Pictures of the American Medical Association. This new mimeographed list includes nine pages of addresses of the major loan and rental libraries, the state health departments' film libraries and references to printed lists and catalogs. Copies are available from: Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Among grants awarded by the Microbiological Institute of the National Institutes of Health recently was one to Indiana, to Kenneth N. Campbell, University of Notre Dame, in the amount of $3,000, for research of the synthesis of potential chemotherapeutic agents for amebiasis and schistosomiasis.

Dr. Nicholson J. Eastman, professor of Obstetrics at Johns Hopkins University, a former member of the Indiana State Medical Association, and a graduate of Indiana University School of Medicine, was elected president of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons at its annual meeting in August at The Homestead, Hot Springs, Virginia.

The Psychosomatic Forum will meet on the first Monday of each month, beginning October 1, at 8:00 P.M., in the Clinical Auditorium of the Clinical Building at Indiana University Medical Center. Further announcement pertaining to the programs will be made at a later date.

VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of three hundred dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Saint Louis, Missouri, May 1, 2, and 3, 1952, providing essays of sufficient merit are presented in competition. For further information, write to the Corresponding Secretary, Dr. George C. Shivers, 100 East Saint Vrain Street, Colorado Springs, Colorado.

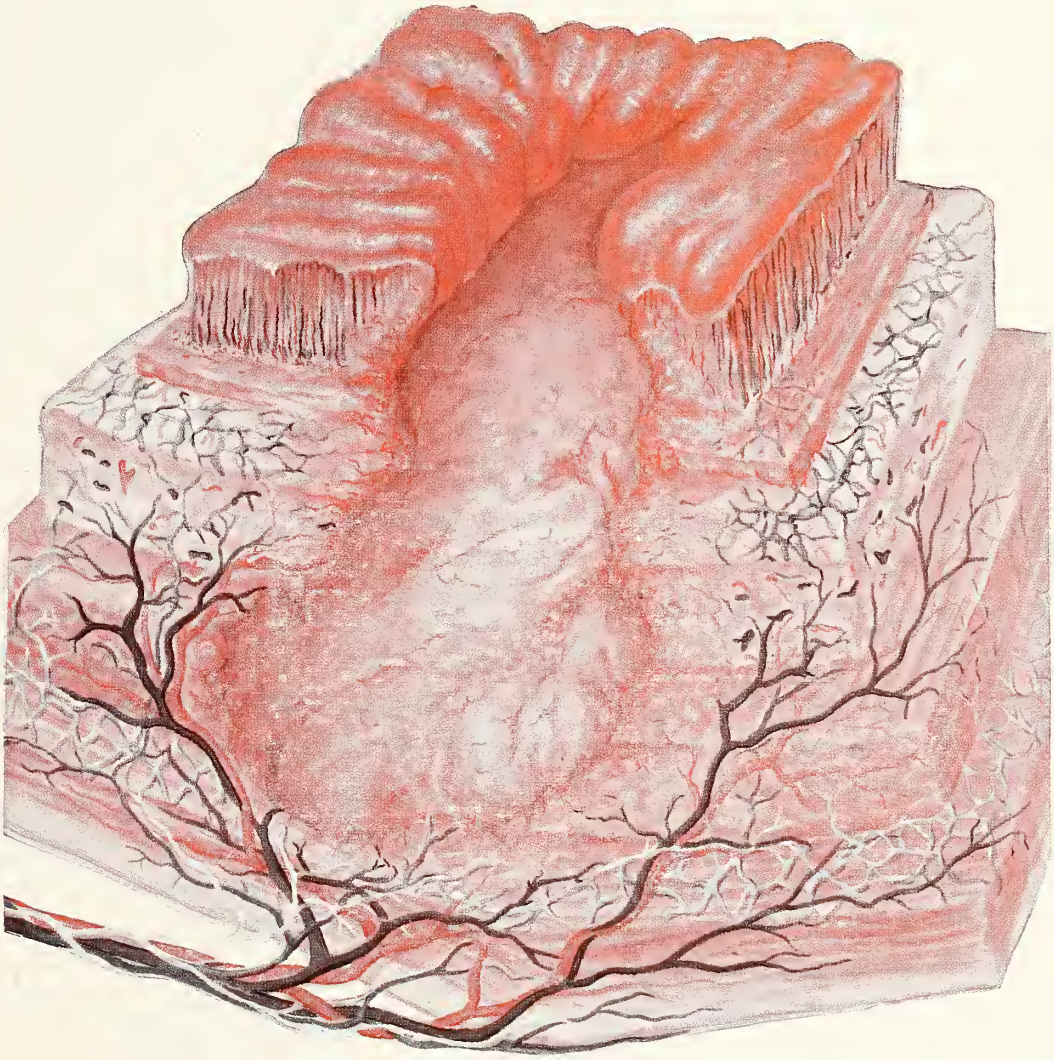
ESSAY CONTEST

The American Dermatological Association is again offering a prize of three hundred dollars for the best essay submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate younger investigators to original work in these fields. Further information regarding this essay contest may be obtained by writing to the secretary of the American Dermatological Association, 102 Second Ave., S. W., Rochester, Minnesota.

ESSAY AWARD

The Board of Regents of American College of Chest Physicians offers a cash prize award of two hundred fifty dollars ($250.00) to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest disease.

Further information may be obtained by addressing American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.



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Dr. Howard J. Henry is now associated in general practice with **Dr. Clark McClure** at 107 South Main Street in Knox.

Dr. James H. Bivin, formerly of Indianapolis, has opened an office in Carmel for the general practice of medicine. A graduate of Indiana University School of Medicine, Doctor Bivin served as a member of the staff of Riverside General Hospital in California.

Dr. Robert F. Cavitt, of Connersville, has again entered the service. He reported to the 3810th Medical Group at Maxwell Air Force Base at Montgomery, Alabama, in August. Since his release from service during World War II, he has been associated in practice with **Dr. F. B. Mountain** at Connersville.

Dr. Frank C. Donaldson, obstetrician and gynecologist, has opened an office at 812 Anderson Bank Building, in Anderson. For the past two years he has been senior resident in obstetrics and gynecology at St. Elizabeth Hospital, in Lafayette. A graduate of Indiana University School of Medicine, Doctor Donaldson served his internship at St. Elizabeth Hospital, and served as chief of obstetrics and gynecology at the William Beaumont General Hospital in El Paso, Texas, from 1947 to 1949.

A graduate of Loyola University in Chicago, **Dr. C. M. Gillespie** has opened an office for the practice of medicine in Medaryville.

Dr. Donn Hunter, previously of Converse, has opened on office for the general practice of medicine in Greenfield. A graduate of Indiana University School of Medicine, Doctor Hunter served his internship at the Methodist Hospital in Indianapolis.

A native of North Manchester, **Dr. E. Everett Lefforge** recently opened an office in Veedersburg. He is a 1943 graduate of the University of Chicago School of Medicine, served in the Army Medical Corps for twenty-seven months, and then entered mission work in Africa under the Evangelical United Brethren Board of Missions, where he served for three years. Since his return from Africa, he served a general residency in the Evangelical Hospital in Chicago.

Announcement has been made of the association of **Dr. Eugene F. Senseny** with **Dr. Richard M. Craig** in the general practice of medicine and surgery, at Fort Wayne. Doctor Senseny entered the Army Air Force in 1942, and flew with the U. S. Eighth Air Force from England. Following his discharge, in 1945, he completed his medical education, and graduated from Indiana University School of Medicine in 1950. He served his internship at the Milwaukee County Hospital, in Wisconsin.

A former resident of Lawrence County, **Dr. William Scharbrough** has opened an office for the general practice of medicine in Shelbyville. He graduated from Indiana University School of Medicine in 1950, and interned at Indianapolis General Hospital. He is a veteran of World War II, having served as a pharmacist's mate with amphibious forces in the Pacific for three and one-half years.

Dr. Ralph Townsend recently assumed his duties as clinical director of the Beatty Memorial Hospital in Westville. A graduate of Cornell University, Doctor Townsend interned at the Illinois Research Hospital and served a residency in internal medicine at the New York Hospital. He also served a two-year psychiatric residency at the Bronx Veterans Hospital.

Dr. Chester L. Waits, of Colfax, has entered the armed services. He reported on August 26 to Brooke Medical Center, at Fort Sam Houston, Texas.

Dr. Alvin F. Wiersma has become associated with the Davis Clinic in Marion, as supervisor of a department of obstetrics and gynecology. He is a graduate of the University of Michigan School of Medicine, and served a rotating internship at St. Mary's Hospital in Grand Rapids. Following service with the U. S. Navy Medical Corps from 1946 to 1948, and service at the U. S. Veterans Hospital at Capital Point, New York, Doctor Wiersma served an obstetrical and gynecological residency at the Syracuse University Medical Center. He then served as senior resident in obstetrics at the Memorial Hospital in Syracuse.

Dr. Philip E. Yunker, of Evansville, is taking postgraduate work in general surgery at Cook County General Hospital in Chicago.

Dr. Robert M. Raber, who recently completed a residency at the Cold Spring VA Hospital, in Indianapolis, is now associated in the practice of plastic surgery with **Drs. Harold M. Trusler** and **Thomas B. Bauer**, at 1015 Hume Mansur Building, in Indianapolis. Doctor Raber is a 1944 graduate of Indiana University School of Medicine, and a veteran of three years Naval service.

Upon completion of his radiological work at the Indiana University Medical Center, **Dr. John S. Scott** is now in private practice in LaPorte. A 1944 graduate of Indiana University School of Medicine, he is an Army veteran with nearly five years of service.

Dr. Harlan B. Moss, a 1944 graduate of Indiana University School of Medicine, has opened an office at 144 East 22nd Street in Indianapolis.

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A.M.A. WASHINGTON OFFICE NEWS

U.M.T. Commission Receives A.M.A. Views On Medical Aspects of Training Program. Dr. James C. Sargent, chairman, Council on National Emergency Service, A.M.A., has presented to the National Security Training Commission for consideration "five cardinal elements, essential to the health and medical care of our Nation." Points made by A.M.A.:

1. Continuation of pre-professional and professional education for qualified students—youths whose aptitude or previous accomplishments indicate they can make their best contribution to the nation as trained professional men should be placed in a *category at or before reaching age of induction that will permit them to continue their education without interruption.*

2. Performance of pre-induction, induction and periodic reserve physical examinations—use of full-time medical personnel of armed forces for these purposes is undesirable and unnecessary. Accordingly such *examinations should be performed by civilian physicians on a fee basis* or by reserve personnel, for which reserve credit would be given.

3. Extent of medical services to be provided members of National Security Training Corps—(a) Corrective treatment and rehabilitation of 4-F's should not be assumed by the Federal government as this would merely be another form of socialized medicine. (b) Medical care during basic training should be same as that currently furnished personnel of armed forces and whatever added medical personnel is required should be obtained without enlarging medical corps of the three services. (c) Medical care should not be provided during reserve status for conditions not arising as direct result of active duty.

4. Eligibility of National Security Training Corps members and reserve components for veterans medical benefits—A.M.A. opposed to extension of such care for non-service-connected conditions, to peace-time veterans. Use of V.A. facilities for such purposes would add growing strain on health and medical manpower resources.

5. Source and selection of medical and allied professional personnel—A.M.A. favors establishment of a national civilian agency to insure the proper distribution of medical and other health reserves between civilian and military needs.

Major Revision of Sickness Survey Bill Forecast. A major revision of the sickness survey bill (S. 1328) is in prospect, according to reports from the Senate Health Subcommittee. It is understood the Subcommittee is considering recommending *no action* on the survey itself at this time, but voting *authorization for a study of techniques for conducting the survey.* This is in line with advice from *Surgeon General Scheele* of Public Health Service, who suggested holding up the $750,000 survey, but voting about $200,000 to finance research in methodology. A.M.A. opposes the full survey as unnecessary, because of other surveys in the health fields now under way, but it approved a methodology study bill in the last Congress.

September Draft Calls On Doctors Postponed. As anticipated, Defense Department has postponed its *September* call for Priority I physicians through Selective Service. During the month, 152 were scheduled to be inducted. The August call for 333 also was postponed. The Department explains that sufficient men are applying for reserve commissions and volunteering for active duty to make the draft calls unnecessary.

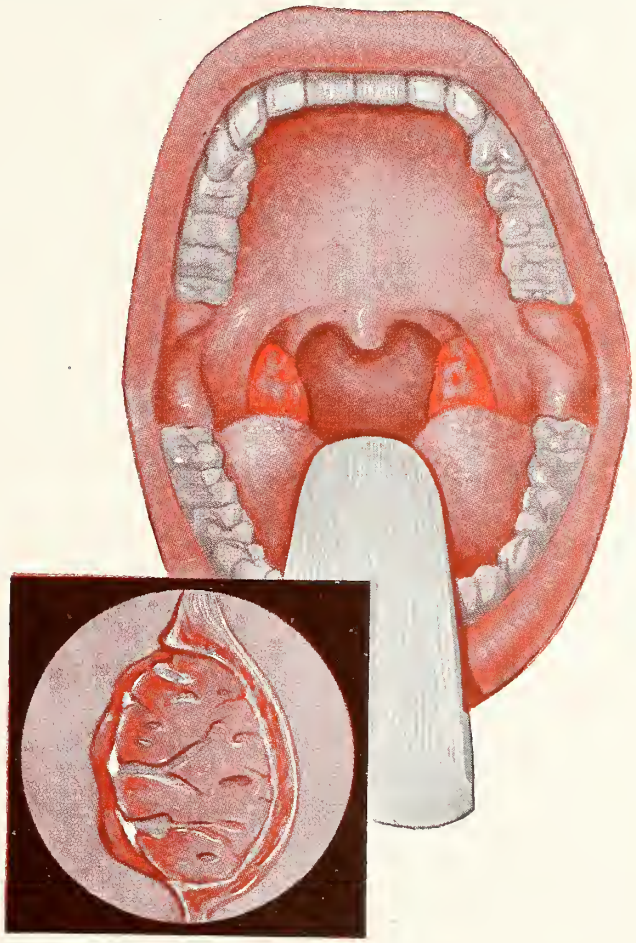
Plasma Supply 'Woefully Inadequate,' Defense Department Says. In preparation for start of the nationwide blood donor campaign Sept. 10, Defense Department discloses these facts about the plasma supply:

1. Supplies of *plasma* have been "gravely depleted by demands of the Korean campaign. Every possible effort must be made to supply whole blood in quantity from all available sources."

2. *Processing capacity* for converting whole blood to plasma has been increased, but a falling off in donors means this *new capacity is not being used.* "Supplies of whole blood today are woefully inadequate," Defense Department says, "and the essential reserve is not being created."

3. The campaign aims at procuring 2,800,000 pints of blood by July, 1952. To reach this total, the number of donors *must be increased more than seven-fold.* Approximately 300,000 pints will be needed each month to attain the goal; in the most recent month for which figures are available, only 40,000 pints were donated.

Outside Defense Department and the military services, the campaign will be coordinated by Red Cross. Meanwhile, Defense Department itself is starting an independent effort, directed toward military personnel and civilian employes of the department. Although the *plasma* situation is approaching the desperate stage, Red Cross to date has been able to supply all military requirements for *whole blood.*



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Sayer, R. J.; Michel, J.; Moll, F. C., and Kirby, W. M. M.: Am. J. M. Sc. 221:256 (March) 1951

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Indiana University News Notes

Grants totaling $68,267 for research and equipment in the laboratories of the James Whitcomb Riley Hospital have been announced by the Riley Memorial Association. The new grants bring to a total of $233,345 allocations made by the association in the past 18 months for research at Riley hospital.

The new grants were voted by the Riley Association board of governors, headed by Perry W. Lesh, on recommendation of a committee representing the Medical Center.

The new research and service laboratories, one in bio-chemistry for the study of children's diseases from the chemical standpoint, and the other in orthopedic surgery, will be established under the new grants.

Other studies covered by the new grants include: the possibility of transplanting embryonic tissue of the endrocrine glands to correct certain deficiencies in this regulatory system of body functions; use of substitutes for blood plasma in combating shock; possible role in peritonitis of an enzyme found in the intestinal tract; tubular field vision; possibility of transplanting entire growing units of bones and the use of metal pins to stimulate the growth of long bones; use of cortisone in preventing excessive fibrous growth in the repair of wounds; cause and treatment of club foot; disturbances of blood fluid function and metabolism; conduction of sounds within the heart to the chest wall; humidity's role in respiratory disease treatment; growth of cancer in bones, and specialized investigations of such diseases as infectious diarrhea.

Installation has been completed on the ambulance signs for the Riley, Long and Coleman hospitals. These signs are illuminated and are installed in order to assist ambulance drivers and others to locate the proper emergency entrances to the hospitals.

The Riley sign is located opposite the entrance to the ambulance drive. The Coleman sign is on the marquee over the north entrance to the hospital and the Long sign is located on the west door of the ambulance entrance.

Dr. T. S. Malinowski, a Fellow in Gastro-Enterology and assistant professor of Military Science and Tactics, has been promoted from the rank of Major to Lieutenant Colonel in the Medical Corps of the U. S. Army.

The Rotary Convalescent Home on the I. U. Medical Center campus has been temporarily closed with the transfer of the few patients to Ward K at the Riley Hospital. The facilities at Rotary are on a standby basis, permitting immediate reopening in case of need. Transfer of the patients does not affect the Child Guidance Clinic located on the third floor of the building. The north entrance, leading to the clinic, remains open.

Dr. Charles Buck has returned to the Medical Center to complete his residency in Pathology after having spent a year with the 406th Medical General Laboratory in Japan.

Captain Oscar Green, 1947 graduate of the School of Medicine, has been transferred to the Department of Otolaryngology at the Army Medical Center in Washington, D. C., after being stationed at Camp Atterbury's Army Hospital for several months.

A series of special events have been given and are in the planning by groups interested in the Riley hospital and the research program dealing with diseases of children. These affairs, each of which results in a contribution for the present and future care of boys and girls, are an indication of the widespread public interest in the hospital and its activities.

A group of children living on East Kelly Street in Indianapolis have had a series of selling projects and collected the sum of $120, which they presented to the hospital recently. This was the third year the group has given a neighborhood benefit for Riley.

The Broad Ripple Sub Deb Club gave a gift of money to the hospital a few days ago. Organized teen-age groups in Indianapolis have previously contributed several hundred dollars for the installation of the modern oxygen system at Riley hospital.

The Crosstown Merchants Association of Indianapolis staged their annual street fair August 2 and 3. Proceeds of the fair will be turned over to the Riley hospital. The organization hoped to secure enough funds to refurnish the Newby Clinic at the hospital.

Local Eagles Lodges sponsored a baseball game, Indianapolis vs. Columbus, at Victory Field August 29 as a means of supplementing last year's gift of several hundred dollars to the Riley Research Fund.

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOKS RECEIVED

LET'S HAVE HEALTHY CHILDREN. By Adelle Davis, M.S., former dietitian at Bellevue Hospital, New York City, and supervisor of Health Education in public schools at Yonkers, N. Y., now a consulting nutritionist in Los Angeles. 314 pages, including table of food analysis. Price $3.00. Harcourt, Brace and Company, Inc., 383 Madison Avenue, New York 17, N. Y., 1951.

LET'S COOK IT RIGHT. By Adelle Davis, M.S. A new edition of her book published in 1947, valuable now as a tie-in with Let's Have Healthy Children. 626 pages. 350 basic recipes and over 3,000 variations. Price $3.00. Harcourt, Brace and Company, Inc., 383 Madison Avenue, New York 17, N. Y., 1947.

LOW-SODIUM DIET. A manual for the patient by Thurman B. Rice, M.D., Professor of Public Health, Indiana University School of Medicine, Indianapolis. 103 pages; 14 food charts. Price $2.75. Lea and Febiger, Washington Square, Philadelphia 6, Penna., 1951.

METABOLIC METHODS. Clinical Procedures in the Study of Metabolic Functions. By C. Frank Consolazio, Chief of Biochemistry, United States Army Medical Nutrition Laboratory, Chicago; Robert E. Johnson, M.D., Professor and Dean of the Department of Physiology, University of Illinois: Evelyn Marek, M.A., Biochemist, U. S. Army Medical Nutrition Laboratory, Chicago. 271 pages, with numerous illustrations, figures, tables and charts. Price $6.75. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Mo., 1951.

CLINICAL PEDIATRIC UROLOGY. By Meredith Campbell, M.D., Professor of Urology, New York University Post-Graduate School. With a section on Nephritis and Allied Diseases in Infancy and Childhood by Elvira Goettsch, M.D., Associate Professor of Pediatrics and John D. Lyttle, M.D., late professor of Pediatrics, University of Southern California. 1,113 pages with 543 figures. Price $18.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa., 1951.

CLINICAL AND ROENTGENOLOGIC EVALUATION OF THE PELVIS IN OBSTETRICS. By Howard C. Moloy, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University and Sloane Hospital for Women. 119 pages, 68 figures. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa., 1951.

BOOKS REVIEWED

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY. By W. A. Newman Dorland, M.D., former member of the Committee on Nomenclature and Classification of Diseases of the A.M.A. 22nd Edition. 1,736 pages, with 720 illustrations, including 48 color plates. Price $10.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa., 1951.

The 22nd edition of Dorland's American Illustrated Medical Dictionary has been completely reset, in larger, more readable type, and almost entirely re-illustrated. Two thousand new words have been added, and no older words have been deleted unless it is certain there will be no occasion for their use.

IMMUNOLOGY. Third Edition. By Noble P. Sherwood, M.D., University of Kansas, Lawrence, Kansas, 731 pages, with 21 figures and 7 color plates. Price $8.00. The C. V. Mosby Company, St. Louis, 1951.

This book, in its third edition, continues to be an outstanding contribution to the medical profession, clinical pathologists, research workers, teachers, and all students of the interactions of the mammilian host with living organisms, and the many inanimate chemical substances with which this relatively new science has dealt. Many of the standard immunologic procedures for diagnosis and potency tests are included.

The unique feature of the work is its treatment of each subject from its first discovery through the developments, bringing the reader as near to the modern picture as is possible in a textbook. Because of its extensive use of medical literature and its complete bibliographic listings at the end of each chapter, it is a valuable reference book.

The book hardly reads like a novel but it is quite easy to read considering the great complexity of the subject covered. To this reviewer the factual information is accurately and clearly stated.

This work will find a wide use by many in the field of medicine and allied sciences.

C. G. C.

PHILOSOPHY FOR THE COMMON MAN. By Heinrich F. Wolf, M.D. 189 pages. Price $3.50. Philosophical Library, Inc., 15 East 40th Street, New York 16, 1951.

If a so-called common man attempted to read this book, he would become lost in the jungle of philosophical verbage and untranslated German and French quotations. The theme of this work is to demonstrate the incompatibility of scholastic philosophy and exact science. The author, who is a physician, was a student of the German philosopher, Hans Vaihinger. This work is based on the principles of the PHILOSOPHY OF AS-IF, propounded by Vaihinger.

Although it contains few original ideas, the work may be of interest to the student of philosophy, but could never become popular because of its anti-religious tone. It would be difficult to evaluate this book as a contribution to medical literature.

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Deaths

Joshua L. Blaize, M.D., a resident physician at the Indiana Village for Epileptics for the past eight years, died on August 8 at his former home in Sandborn. He was seventy years of age, and had been ill for several years. A 1907 graduate of the Kentucky School of Medicine, in Louisville, Doctor Blaize was a member of the Henry County Medical Society, the Indiana State Medical Association, and the American Medical Association.

W. Donald Davidson, M.D., former Evansville physician, died on August 22 in Long View, Texas, after a long illness. He was forty-four years of age. He was a 1931 graduate of the Indiana University School of Medicine, and a veteran of World War II. The son of the late Dr. William R. Davidson, he had practiced in Evansville before going to Fort Worth, Texas, approximately one year ago, to head the orthopedic department at Cook's Memorial Hospital there. He was a former member of the Vanderburgh County Medical Society, the Indiana State Medical Association, and the American Medical Association.

John W. Kistner, M.D., of Elkhart, died on August 13, at the age of seventy-four. He had been ill for several months. Doctor Kistner had practiced in Elkhart since graduating from the Rush College of Medicine, in Chicago, in 1902. He was a member of the Elkhart County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Thaddeus C. Goraczewski, M.D., of South Bend, died suddenly on August 23, at the age of forty-four. He graduated from the Marquette University School of Medicine, in Milwaukee, in 1936, and had practiced in South Bend since that time. He was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Thomas L. Keefe, M.D., of Logansport, died on August 21, at Rochester, Minnesota, at the age of fifty. He was a graduate of Harvard Medical School in 1928, and practiced in Earl Park before going to Logansport. Doctor Keefe was a veteran of World War II, and was a member of the Cass County Medical Society and the Indiana State Medical Association, and was a fellow of the American Medical Association.

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In these past few years we have taken the lead in our communities in an effort to bring before the public the picture of socialism, which has as its cornerstone Compulsory Health Insurance—so Nye Bevan said when he resigned from the British Cabinet this past April because the people of England were having to pay half the cost of dentures and eye-glasses. The very foundations of Socialism were being weakened! Every Auxiliary has procured resolutions from their own community organizations, opposing Compulsory Health Insurance and favoring the Voluntary way. Indiana, with our assistance, leads the nation, with the greatest number of resolutions sent to our congressmen in Washington. We work on the drives of Voluntary Health Agencies and the Community Chest. Many of us offer nursing scholarships in our own or nearby hospitals, and contribute other worthwhile, philanthropic services to our communities. One of our biggest achievements has been the promotion of friendly relations among ourselves. The WOMAN'S AUXILIARY to the INDIANA STATE MEDICAL ASSOCIATION can stand on this record and well be proud of its achievements.

For you who have seen fit to withhold consent for the formation of an Auxiliary in your County, I am asking that you reconsider this action and give those of us responsible for organization in the Auxiliary the privilege of meeting with your wives. We want to tell them, first-hand, what we have to offer and what an opportunity for service to their husband's profession and communities is here, just for the asking. If we cannot convince your wives that we have a constructive program, combined with an opportunity for agreeable social relationships, we will fold our tents and creep away.

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Relationship of Stress to Autonomic Lability

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance. [1,2] Such states may involve any one of the organ systems or several at one time. [1,3] The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifestations	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references [3,4,5,6,7] given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. [8,9,10]

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THE DOCTOR'S PLACE IN THE SUN*

ALFRED ELLISON, M.D.

SOUTH BEND

THE doctor has a place in the sun. The events of the past few years have focused attention upon this place. The history of our modern day will reveal to us, I am confident, that it was by a strange act of providence that the medical profession of America has been thrown into a place of great importance in the affairs of our nation in the past few years. History will record that while other segments of our society have fallen, to some degree, under socialism, it was the medical profession which was the first to be threatened with complete domination. To our eternal glory, we stood steadfast in the path of the Planners in this effort to socialize us, and eventually socialize the whole of America. Ours apparently was going to be an easy segment of American life to socialize; witness the fact that in many countries which are largely socialistic, medicine was among the first to fall. It would appear that medicine should be easy to socialize, because nothing quite pulls on the heart strings like illness and kindred misfortune. And in their efforts it is apparent to all of us that they prey on the heartstrings of our fellow Americans rather than honestly appealing to their intellect.

Thus, it may be said that we, like the legendary Dutch boy holding his hand over the hole in the dyke, so far have stopped the Planner's efforts to take us over. Because of our being so attacked, we appreciate the schemes and the intentions of the Planners as few other Americans do. When any danger comes to one's own door, he is more alarmed than when it comes to his neighbor's. Because we have become so acutely aware of this threat to our profession and to America, it gives us a tremendous responsibility to warn and alert our fellow countrymen to this great peril. It emphasizes that we have a profound responsibility, as physicians, to spearhead the renaissance of freedom. It appears beyond contradiction that if the physicians of America had not been unified in resisting this tremendous effort to bring about our socialization we would have long since succumbed to the dictatorship of another bureau in Washington. If the American Medical Association and the various state medical associations did not exist, we would have socialized medicine today. This calls our attention to the power of our organization. It calls attention to the fact that when you are in the right and have the courage to state your case, the American people are quick to affirm their intention to keep America free. It follows, of course, that each of us must actively support his medical organizations, not only with his dollars, but with his earnest personal efforts, for the sake of his own freedom and the freedom of all America. Our primitive instinct of self-preservation, alone, should prompt us to give this support.

Who wants socialized medicine in America? Who wants the socialization of anything in America? I am sure that the belief is commonly held that it was the people of America who rose up and demanded socialized medicine. Of course, this is not the fact. With your indulgence, I would like to read to you from the Congressional Record. This quotation is from the Honorable Forrest A. Harness, who represented the Fifth Indiana District in Congress from 1939 until his replacement two and one half years ago. Mr. Harness was the chairman

* President's address, presented at the annual convention of the Indiana State Medical Association, at Indianapolis, on October 30, 1951.

of a Congressional Subcommittee on Publicity and Propaganda in the executive departments of our government. Mr. Harness made the following statement, and I quote, "Probing the operations of 'our most dangerous lobby' a Congressional subcommittee, of which I am chairman, has uncovered startling evidence of attempts by federal employees to make big government bigger and to extend by another vast grant of power, the authority of the state over the lives of all of us.

"Our committee has found that government employees are back of the campaign to pressure Congress into passing a national compulsory health insurance law. This campaign was planned inside the government, on government time, supported by the government's publicity and propaganda machine and paid for by the taxpayer. Confronted with these facts, our committee—Democrats and Republicans—voted unanimously to expose them and to turn the evidence over to the FBI and the Department of Justice for prosecution under the law which forbids federal employees to use federal funds to influence legislation."

This official record, which nobody has disputed, gives the clue to the fact that there is a systematic plan on foot to take over America, step by step. It gives the clue that explains the many long steps we have taken down the road to the Welfare State with its rosy promises of security to our people, steps that already have built up enormous bureaucracies which operate these schemes, steps which are largely responsible for placing over two and one-half million people on the federal payroll, steps which are the principal cause of our public debt of two hundred fifty-eight billion dollars, and this debt exists in the face of the largest employment and the highest taxes in our history.

We are witnessing the spectacle of our high officials advocating measures which will rob each of us of the liberties and the opportunities which are our birthright under the Constitution and Bill of Rights. For twenty years they have advocated and practiced a program of impoverishing America. Mind you, there are only two sources of funds with which to operate our federal government. One is from taxation upon the people and the other is by the operation of the printing press. Their deficit financing has pushed our public debt to over a quarter of a trillion dollars and is causing a dilution of our money so that those who have passed the peak of their careers have real reason to wonder if their savings will see them through. We dare not confuse inflation with prosperity. The printing press has given our economy strychnine when it really needs bread and butter. Communist hordes and communist bombs will not be necessary to destroy America if the policy now followed by our leaders to bankrupt our country is allowed to continue. History reveals that six former democracies have passed into oblivion over exactly the same route. These leaders have declared open war on the free and independent practice of medicine. They have boldly included this in their party platform. Let us be fools no longer. Just ordinary patriotism and ordinary courage should impel each of us to think no longer as a partisan, in the political sense, but to think now only as Americans.

The Planners have focused attention upon our shortcomings. Every human being and every group of human beings has shortcomings. May I submit to you that criticism, if it strikes a responsive cord, can be very beneficial. I am confident that if each of you will examine your experiences of the past, you will agree that you have frequently profited much by criticism if it had merit. So it is my firm belief that this attack upon us of the medical profession can and should be converted by us into profit. It is no secret that a small percentage of our members, being human beings, have fallen prey to avarice and to other human frailties. We often hear charges leveled against some of our associates of excessive fees and unwillingness to make night and emergency calls. The charge of excessive fees, however, leads the list of complaints. A few weeks ago a layman friend of mine, who had just returned from a trip to England, revealed to me an interesting sidelight about the attitude of the English people toward their medical profession. He assured me that the people of England made little or no effort to oppose the socialization of their doctors, for the reason that the English doctors had become quite smug. It seems that they had concluded that they were in a class by themselves and the public had recognized this attitude.

While I cannot believe that we American doctors can be accused of living in an ivory tower to this degree, not infrequently we hear a substantial citizen saying that some doctors he knows are apparently too satisfied with themselves. It must be apparent to you that my popularity will not be increased by talking about the shortcomings of some of us, but I must say to you that I would be derelict in my duty if I did not emphasize the fact that untold harm comes to every Hoosier doctor because of the unfortunate conduct on the part of a few of our members. It is so obvious that our obligations to the public, to ourselves and to the sons of medicine who will follow us, require that we make a serious effort to clean our own house. That occasional member who brings ill repute to himself and to his associates by his unfortunate conduct should and must be brought before his county society for a review of his conduct. Medicine's position in modern society is too precarious for the derelictions of a few to jeopardize our freedom in the independent practice of medicine. But I am confident that we will have the good sense and the qualities of gentlemen which will restore us once more into the good graces of the American public, from which in recent years we have obviously slipped.

You say that others, too, treat the public poorly on occasion and I hasten to agree. It seems that lately there has been too much of a spirit of "I'll get mine." That the influence of communism, with

its philosophy of materialism versus Christianity, has insinuated itself into every segment of our society, no one can deny. But I say to you that the public expects and deserves good things from the medical profession. With our heritage of respect and high position in the eyes of the people always, we must be constantly mindful of our priceless obligation and our priceless opportunity to help lead the world back to the practice of the Golden Rule. If doctors become ordinary, then to whom can civilization look for example and inspiration?

We must squarely face the fact that the socialization of medicine is merely a part of the plan to socialize all of America. Let us not be afraid, honestly, to appraise the situation that exists today in our country; in the country founded only yesterday, as history goes, by men and women who fled from Europe to escape religious and political tyranny; in the country which has made it possible for the poor to live, as well as the kings of yesterday; in the country where every man has enjoyed the privileges and liberties, under the Constitution and Bill of Rights, that only two percent of men have enjoyed since the birth of Christ; in the land where a man's achievements are only limited by his ability and his gumption.

Over this land there has grown a cloud in the past few years—an ominous cloud—that fills us all with fear and apprehension. We have seen our government infiltrated by forces and influences foreign to the American way of life. We have seen our elected representatives fall prey to the influence of men who would destroy America. That these men are the tools—wittingly or unwittingly—of an international conspiracy we call communism, no one with courage can deny. Let us candidly face some of the facts. The total government expenditures under the first thirty-two presidents, covering a period of one hundred fifty-six years, is less by several billions than the expenditures in the past six years under the current administration. Less in the first one hundred fifty-six years than in the last six years. As I said earlier, the public debt has risen to over a quarter of a trillion dollars. In nineteen of the past twenty-one years the government has spent more than it has taken in. This reckless policy continues and a day of reckoning is inevitable. If all the life insurance policies in America were converted to cash, this would support the federal government for less than a year. If all the homes in every city of our land were sold, it would last less than eight months in paying the federal bills. If all the farms, farm animals and equipment in all the states were sold, this sum would only supply money for current expenses in Washington for less than seven months. The average man works now fifteen weeks out of every year to satisfy the tax demands of his government. The value of a $10,000 life insurance policy in 1940 has today shrunk to less than $6,000 as a result of the dilution of our currency and the end of this trend is not in sight. We have seen an unwarranted domination of America by the executive branch of our government, manifested by these two and one-half million federal employees, who are, by and large, bureaucrats. The position of the legislative and judicial branches has, at the same time, suffered in stature. The effort to pack the Supreme Court is a matter of history. If those of you who have children love these children and want them to have a decent future in a free America, you must recognize the serious crisis which confronts us.

We should beware of the politician whose heart bleeds for the people. We should clearly recognize that the greatest blessings to befall the common man are not the hollow solicitudes of our modern leaders, but the greatest blessings to befall the common man are the opportunities and the freedoms provided him in our Constitution and Bill of Rights one hundred sixty-three years ago. No other form of government has ever equalled it.

You may ask yourself, just what liberties have we lost so far. Let me remind you that you have lost the liberty to keep, or to use, or to save that which you earn. You have lost even a greater freedom and that is the freedom of your ballot, because the votes of six or seven millions of our citizens are neutralized by the political machine made up of the two and one-half million bureaucrats and their families.

The spirits of the patriots who gave us this land, the Washingtons, the Jeffersons and the Lincolns, must be anxiously watching over us from some vantage point tonight, wondering what kind of citizens we will turn out to be. The spirits of these ancestors must be pleading that each of us awakens to his responsibility in this hour of crisis. Pleading that we awaken before our opportunity to salvage our country is gone. We have got to get rid of the fixed idea that liberty is imperishable in America.

We may hope that the threat of this world-wide conspiracy serves so to alarm our people over the loss of their freedoms as to cause a revival of the old-time patriotism which inspired our George Washingtons and our Paul Reveres, the patriotism which created America and which jealously guarded it in its infancy. We have grown complacent and in a democracy we dare not be complacent. America was not founded by weaklings. Our heritage of freedoms was won by men who bled and died that we might enjoy the blessings of the greatest country in all the world's history. We would be poor men indeed if we failed to fight now to retain these blessings for ourselves and our posterity.

TESTICULAR TUMORS WITH SEVEN CASE PRESENTATIONS*

Charles J. Van Tassel, Jr., M.D.†

INDIANAPOLIS

THE CASES under review comprise all the malignant testicular tumors treated at St. Vincent's Hospital, Indianapolis, during a two and one-half year period, July 1, 1946, to December 31, 1948. During this period 6,100 male patients were admitted, and of these 4,237 were male surgical patients. In this short period there were seven malignant tumors, an incidence of one in every 871 male patients admitted.

The malignant tumors were classified as four embryonal carcinomata, one seminoma, one malignant teratoma and one malignant teratoma-embryonal carcinoma (separate growth in the same testicle). The pathological report on these tumors was based on the classification recently offered by Friedman and Moore.[1]

The ages in this series varied from 29 years to 37 years. The average age of the entire series was 33.5 years.

The most usual presenting symptom was that of a gradual painless enlargement of the affected testis which was first noted quite accidently by the patient. The average duration of symptoms of the entire series prior to treatment was 3.3 months. The period varied from one month to 11 months. These cases were recognized relatively early in relation to comparative series. Only one case gave a history of antecedent injury. The occurrence of a tumor in an undescended testicle was not noted, except for one case which was omitted fron this series because no biopsy specimen was obtained and follow-up was unsuccessful after irradiation.

In this series the hormone test was of little help in diagnosis. It was utilized preoperatively in all the cases and the reaction was positive in one instance. The case of the malignant teratoma gave a positive Friedman reaction.

No case presented clinical evidence of metastases prior to surgery. All patients had a thorough physical examination and all had a preoperative chest film, with the exception of one patient.

All of the patients were treated by simple orchiectomy and followed by postoperative x-ray, with the exception of two cases. Of the latter, one with a teratoma lived less than one year. The other patient is alive 49 months postoperatively, but refuses to be seen for a check-up. Of the remaining five who received irradiation, three are alive, with no clinical evidence of metastases, and two are dead. Of these two, one presented evidence of metastases within four months and died within six months after orchiectomy; the other developed abdominal metastases and died 10 months following orchiectomy.

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INCIDENCE

There is some variation throughout the literature in the reported incidence of testicular malignancy. The general statistical data shows an incidence of 0.5 to 0.6 percent in relation to malignant disease of all organs. Dean,[2] of Memorial Hospital (New York), reports an incidence of 2.09 percent with regard to all other malignant tumors in the male, and 3.29 percent of all tumors of the genitourinary tract. Ormond and Best,[3] of Henry Ford Hospital (Detroit), report that testicular tumors are rare. In their series, between the years of 1923 to 1946 inclusive, during which period 496,211 patients in all were seen, they saw only 40 cases of malignant tumors of the testicle. Tanner[4] states that the malignant testis occurs once in every 2,000 male admissions to a general hospital. The incidence of tumors of the testis at an Army General Hospital during World War II was 7.86 percent of all their malignant neoplasms.[5]

Approximately one-third of all tesicular neoplasms are seminomas, while another one-third is made up by the teratocarcinoma group. The embryonal carcinomata and teratomata as classified by Friedman and Moore constitute about 19 percent and 10 percent respectively of testicular new growths.

Malignancy of the ectopic testicle has been quite controversial, but statistics indicate an incidence of about 11 to 12 percent in undescended testes. Murray and Ewart,[6] in reviewing the literature, showed that malignancies of the testicle comprised approximately 11 percent of a series of 694 cases of ectopic testes. The tumor occurred in the undescended testicle in 97.5 percent of patients who developed a testicular malignancy in the presence of a malplaced organ. In bilateral cryptorchidism with a unilateral testicular neoplasm, a carcinoma of the second testis developed in 24 percent, whereas a second tumor developed on the opposite side in less than 1 percent of cases having both testicles in the scrotum. In a review of their own cases during a five year period, 14 patients were seen with testicular tumors, and of these the tumor was in the undescended testis in four cases, an incidence of over 28 percent. In view of these facts, Murray

and Ewart believe that the ectopic testes must be regarded as a potentially malignant tumor and that a unilateral cryptorchid testicle should be removed if it cannot be replaced in its normal position. About one in 20 abdominal testicles become malignant and only one in 80 testes in the groin become malignant. According to Carroll[4] he does not accept the present high statistics of malignancy in the ectopic testes because he thinks there is reasonable and justifiable doubt as to the accuracy of the factual premises on which they are based. He believes that the potentiality of malignancy should not be the criterion for orchiopexy or orchiectomy.

Bilateral testicular malignancy involvement is occasionally seen but is very rare. However, it is the belief of some that the true incidence is undoubtedly higher than the statistics at hand. Some of the bilateral testicular tumors do not develop simultaneously but occur several years later in the contralateral testicle.

CLASSIFICATION

The majority of testicular tumors fall into one of two categories, either the complex teratomas or the monocellular group. Friedman and Moore,[1] in their review and classifications of 922 tumors of the testes at the Army Institute of Pathology, of Washington, D. C., stated that in 96 percent of the cases only four fundamental structural patterns of tumors were encountered in the period between October 1940, and May 1946. They fell into one of the following categories: seminomatous, embryonal carcinomatous, teratocarcinomatous and teratomatous. The chorio-epithelioma was considered a subvariety of embryonal carcinoma along with the undifferentiated tumors and the tumors of trophoblastic origin. The term, teratocarcinoma, was coined for those tumors which show the presence of adult or embryonic structures derived from more than one primitive germ layer in addition to the malignant element.

This classification is advocated by many of the recent writers on testicular tumors as being practical because of its simplicity and because it is thought to promote a more common understanding among the various investigators. However, in view of the difference in prognosis, Lewis[7] believes that the term, embryonal carcinoma, should be used only in the general classification and the type of most malignant cell recognized in the tissues be used in diagnosis. Sauer, Watson, and Burke[8] suggest that the embryonal carcinoma group be divided into tumors consisting of embryonal carcinomas, plus seminomas and embryonal carcinomas combined with other malignant cell elements.

PATHOLOGY

Nesbit[9] states that the chief point of contention regarding the pathology of testicular neoplasms has been the theory advocated by Ewing, that all testicular tumors arise from a totipotential spermatogenic cell which may produce tissue resembling any or all of the three germ layers, versus the opinion of Chevassu who maintains that the seminoma is a distant entity not arising from a totipotential cell but arising from the lining epithelium of the seminiferous tubules forming a uniform type of tumor. Friedman and Moore,[1] in their review, sharply distinguish between seminoma and embryonal carcinoma despite the coincident occurrence in a fair percentage of cases. They consider them as distinct tumors which differ biologically in their fundamental cell type and in prognosis. They also recognized that a comparably sharp distinction between most of the tumors of the chorio-epitheliomas and embryonal carcinoma group could not be drawn.

They state that seminomas are probably tumors of primordial germ cells and should be called germinomas, and that the embryonal carcinomas and teratoids are neoplastic expressions of the unlimited potentialities of embryonic cells.

The seminomas are characterized by rounded, rather uniform polyhedral cells which often have a clear cytoplasm. The nuclei are round and centrally located. The cells are usually arranged in unorganized masses or cords divided by trabeculae of connective tissue. The differentiated glandular epithelial structures very rarely are produced by seminoma cells. The embryonal carcinoma shows considerable variation in cellular type from neoplasm to neoplasm. The tumor cells are anaplastic and larger than in the seminoma. The cells are epithelial, often columnar and cuboidal, and often form differentiated glandular or papillary structures. The chorio-epithelioma is composed of Langhans cells and multinucleated giant-celled syncytium, its structures duplicating the architecture of the placental villi.

METASTASES

Metastases occur early, and the most common route of spread is by way of the lymphatics to the abdomino-aortic nodes. From there they enter the regional nodes and spread to subdiaphragmatic and mediastinal nodes, thence to the chest. The external inguinal and femoral nodes are rarely involved unless the tumor has perforated the tunica vaginalis or capsule of the testicle and invaded the scrotal wall. Metastasis by way of the veins gives rise to early pulmonary metastasis. Metastases from the seminomas quite often remain confined to the abdomino-aortic nodes. However, as a rule, the embryonal carcinomas and terato-carcinomas metastasize also to the parenchymal organs.

Autopsy material reviewed by Barringer[10] of the Memorial Hospital showed that 72 percent of their cases presented bilateral involvement of the abdomen, either by glands or metastatic involvement of intra-abdominal organs. In 75 percent of their cases with lung metastasis, the liver showed involvement. Twenty-six autopsied cases of testicular tumors (teratomas, embryonal adenocarcino-

ma and embryonal carcinoma-treatment consisted of simple orchidectomy and deep x-ray) from the U. S. Naval Hospital, Brooklyn, showed the liver was the site of metastasis in 69.2 percent, the mediastinum in 80 percent, and the lungs in 84.5 percent. They also reported no evidence of direct extension along the spermatic cord and inguinal regions.[11]

SYMPTOMATOLOGY

The usual initial symptom of a testicular tumor is gradual, asymptomatic and painless enlargement of the affected testis which is often first noticed merely by accident. Occasionally metastatic lesions may produce the initial clinical sign. Trauma and hemorrhage may produce pain and tenderness. Malignancy should be suspected in any case of swelling, especially painless, in the scrotum.

Throughout the literature mention is made of injury or trauma to the testicle as a predisposing factor to the development of testicular tumors, however doubts as to its importance are justified. The statistics vary between 10 and 35 percent of testicular tumors presenting a history of previous injury to the testis. Gynecomastia occasionally occurs as the first sign of a testicular neoplasm without the patient being aware of a scrotal swelling.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis of testicular tumors is often difficult, sometimes impossible, and is chiefly made by exclusion. Gentle bimanual palpation will usually eliminate epididymitis, lesions of the spermatic cord, spermatoceles, and lesions of the surrounding scrotum. It will also indicate a disproportionate heaviness of a testicular tumor. Often the presence of a complicating hydrocele masks a neoplasm, and aspiration of the fluid may be indicated to facilitate differentiation by palpation. Tapping is always contraindicated when the scrotal mass does not transilluminate. In testicular new growths the scrotal skin is not attached to the tumor as in tuberculosis, which latter disease chiefly affects the epididymis. There is often difficulty in the differentiation of calcified hydroceles, hematoceles, and gummata. A flat plate of the scrotum will often help in the differentiation of a calcified hydrocele from calcification of a testis tumor. Calcification of the hydrocele occurs in the periphery while it is usually centrally located in the tumor. In cases that are doubtful, exploration of the scrotum should be done. Serology should be done on all solid masses of the scrotum. An operator should not be condemned for removing a gumma if the patient has one remaining good testicle. The gumma of a testicle eventually atrophies and the testis becomes inert.

The quantitative Aschheim-Zondek and Friedman tests indicate malignancy when positive, but do not exclude it when negative. The amount of hormone in the urine does not indicate the structure of testicular tumor, with the one exception perhaps of a chorio-epithelioma. This tumor produces a considerable amount of gonadotropic hormone. The amount of hormone in the urine after the tumor has been removed and followed by radiation can be used at times as a criterion for both the effectiveness of the therapy and to determine the need for further treatment. All patients with testicular new growths during their preoperative work-up should have chest x-rays and intravenous pyelography.

TREATMENT

The type of therapy to be employed is in dispute. Some advocate irradiation alone; others simple or radical orchiectomy or a combination of both. The standard method of treatment has been simple orchiectomy with high ligation of the cord (and as little manipulation as possible of the testicular tumor), followed in most instances by postoperative x-ray therapy. The preoperative x-ray treatment is seldom used today. Most surgeons have abandoned the radical procedure, which was first described by Chevassu, Young and Hinman,[12] because of the high operative morbidity, the comparatively low percentage of cures, and the demonstration in a large percentage of cases that there is a communication of the retroperitoneal lymph chain with glands above the renal pedicle and into the chest. The operation consists of removal of the testis, entire spermatic cord and vas, and the retroperitoneal lymph chain from the inguinal ring to the renal pedicles.

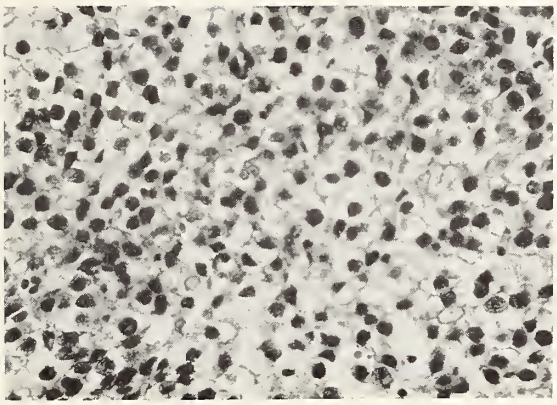
In recent articles Lloyd Lewis[7] advocates that the treatment of testicular tumors must be varied according to the pathologic process presented. He recommends for seminoma, simple orchiectomy plus irradiation because of the known radio-sensitivity of that tumor. For the remaining testis tumors he advocates radical orchiectomy with or without irradiation, depending on the type of tumor. At the time of his last article, he had performed 169 radical resections with no immediate operative mortality. In this group, 65 percent of the patients had no metastatic involvement, 25 percent had operable nodes removed, and in 10 percent they left inoperable nodes.

PROGNOSIS

From the prognostic standpoint, more important than the histopathologic type of tumor, the amount of gonadotropic hormone in the urine, and the postoperative irradiation, is the presence or absence of metastases at time of surgery. Leddy[13] states that two-thirds of patients who do not have evidence of abdominal metastasis at time of irradiation live at least three years. Death usually occurs in the untreated cases within three to 24 months.

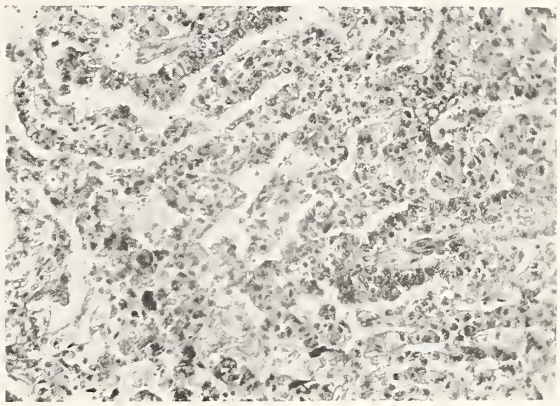
The immediate prognosis for a pure seminoma is good. It metastasizes later and less often than

Figure 1



Case 1. Seminoma. High power photomicrograph showing rounded uniform polyhedral cells with clear cystoplasm and round nuclei having fairly prominent centrally located nucleoli.

Figure 2



Case 2. Embryonal Carcinoma. High power photomicrograph showing large irregular gland-like structures and large irregular spaces into which project papillary epithelial structures.

embryonal carcinoma, disseminates less widely and responds better to irradiation. The adult teratoma, which is a teratoma with no histological, recognizable malignant component, grows slowly and its prognosis is fairly good.

The results of surgery and irradiation of all testicular tumors are most discouraging because in 35 to 70 percent of cases coming to operation, metastasis has already been present at the initial examination. The prognosis of malignant tumors of the testis has greatly improved during the last two decades because of earlier orchiectomy combined with postoperative irradiation.

After orchiectomy, patients should be followed up at intervals of three to six months. The only way to an effective cure is orchiectomy before metastasis has occurred and the wider application of improved radiotherapy. With this, the five year survival rate will increase considerably over its present rate.

CASE REPORTS

Case No. 1—A 37-year-old, white male complained of a painless, progressive swelling of the left testicle, which had been present for at least seven months prior to admission. There was no history of injury. Physical examination was essentially negative except for the left scrotum. The testicle was enlarged about three times normal size, hard and painless. A Friedman test was negative. The preoperative chest film was negative.

Left orchiectomy was performed through an inguinal incision on July 13, 1947. The specimen consisted of a testicle with a homogeneous, grayish white, gross appearance, 9 x 6 x 5 cm. and weighing 178 gm. Pathologic section showed a typical seminomatous pattern (Fig. 1). Roentgen therapy was administered postoperatively, a total of 1400 r. The patient was well and at work 42 months postoperatively and had no clinical evidence of metastases.

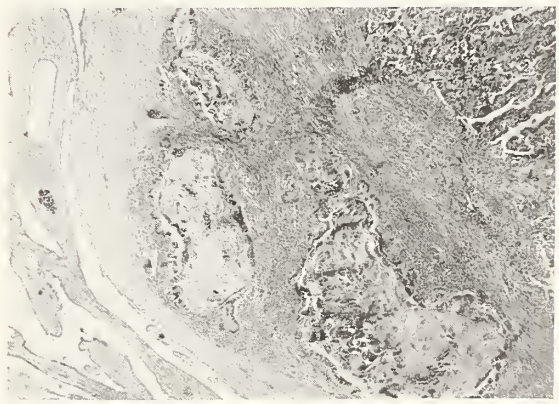
Case No. 2—A 30-year-old man complained of a swollen, heavy left testicle which condition had been present no longer than six weeks before admission. There was no history of injury. On examination, the testicle was not enlarged. However, it was stony hard, especially the lower pole. A Friedman test was negative. The preoperative chest film was negative.

Left orchiectomy was performed August 6, 1948, through a scrotal incision, in the belief that it might be nonmalignant. Gross section of the specimen showed two well demarcated, soft, yellow, necrotic looking areas. The larger area measured 2½ cm. in diameter. The pathologic sections showed an embryonal carcinoma which was highly malignant (Fig. 2 & 3). Despite postoperative roentgen therapy, a total dosage of 1456 r., the patient developed abdominal metastases and died 10 months later.

Case No. 3—A 33-year-old, white man who first noticed pain and swelling in his right testicle approximately 30 days before admission. He associated the swelling with a contusion he had received at that time. On physical examination, he had a firm, large mass in the right scrotum which did not transmit light. A Friedman test was negative, the chest film was negative.

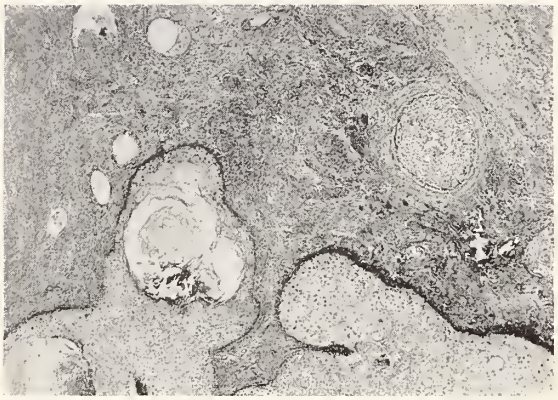
Right orchiectomy was performed March 3, 1947, through a right scrotal incision because of some doubt of its malignancy. The gross testicular mass

Figure 3



Case 2. Embryonal Carcinoma. Low power photomicrograph adjacent to the rete testis.

Figure 4



Case 5. Malignant teratoma. Low power photomicrograph showing large masses of squamous epithelium, many islets of cartilage, and cystic spaces lined by columnar, flat and transitional epithelium.

measured 8 cm. in its greatest dimension. Its shape was roughly that of a normal testicle. On cut surface, most of the mass was composed of yellow, soft, necrotic looking material. The microscopic section showed a highly malignant embryonal carcinoma. Subsequently, he had two series of roentgen therapy, receiving a total dose of 2856 r. He developed metastases within four months and died within six months after orchiectomy.

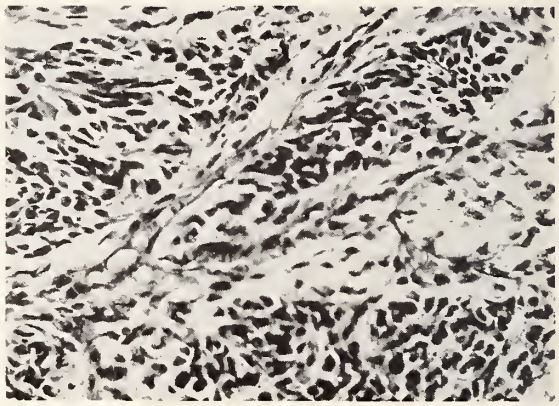
Case No. 4—A 36-year-old, white man who complained of an enlarged right testicle, which condition had been present one month prior to admission. In the beginning, the testicle was tender, but not excruciatingly painful. On examination, the right testicle was stony hard, nodular, and enlarged three times normal size, and was slightly tender. The left testicle was undescended and abdominal in type. A Friedman test was negative. The postoperative chest film was negative.

Right orchiectomy was performed through an inguinal incision February 22, 1946. The testicular specimen weighed 102 gms. There were two separate growths in the mass, one measuring 4 cm. in diameter and the other 3.5 cm. Each mass was well circumscribed and encapsulated. The larger tumor was a malignant teratoma and the smaller tumor was an embryonal carcinoma. Routine postoperative roentgen therapy was administered. The patient was last seen in November, 1950, 45 months postoperatively, at which time he had no clinical evidence of metastases and was feeling well.

Case No. 5—A 29-year-old, white man who complained, on admission, of an enlarged left testicle which was heavy and hard. He had noticed the enlargement one month prior to admission. There was no history of trauma on physical examination. The testicle was about twice the size of the right. It was very hard and nontender. A Friedman test was positive. The preoperative chest film was not done.

Left orchiectomy was performed through a scrotal incision July 1, 1947. The testicular specimen measured 6 cm. in its greatest dimension and the tumor mass measured 5½ cm. in its greatest dimension. It was firm, lobulated and bulged on cut surface. The microscopic section showed a malignant teratoma (Figs. 4 & 5). Roentgen therapy was not administered postoperatively. The patient lived less than one year following his orchiectomy.

Figure 5



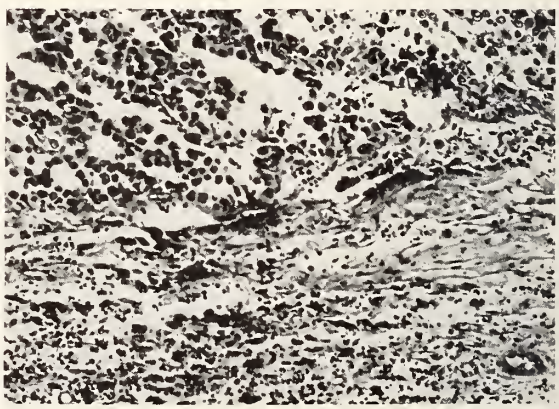
Case 5. Malignant teratoma. High power photomicrograph of dark staining, highly cellular elements and stroma; resembling a sarcomatous lesion.

Cases No. 6 & No. 7—The remaining two cases were those of borderline embryonal carcinoma. Some of the areas of both microscopic sections resembled a seminoma; however, throughout the sections there were areas of multinuclear cells and large masses in which the cells were rather loosely arranged.

The first case was a 36-year-old, white man who, on admission, complained of a tumor in his left scrotum which had been present 11 months. Preoperative chest film and Friedman test was negative. Left orchiectomy and direct inguinal herniotomy was performed August 11, 1947. He received a total of 1,400 r. postoperatively. The patient was well and working 40 months following orchiectomy, at which time he had no clinical evidence of metastases (Fig. 6).

The other case was a white man, 34 years old, who thought he had had a hernia for several months before orchiectomy was performed in October 1946. Preoperative chest film and Friedman test were negative. He refused any postoperative roentgen therapy. A phone conversation with the patient in December 1950, 49 months postoperatively, revealed that he was alive and feeling well.

Figure 6



Case 6. Borderline Embryonal Carcinoma. Medium power photomicrograph of an area resembling a seminomatous lesion and other areas in which there are multinuclear cells and large masses of loosely arranged cells.

SUMMARY

1. The pathology and the classifications of malignant testicular tumors are reviewed.

2. Seven cases of malignant tumors of the testicle, classified as four embryonal carcinomata, one seminoma, one malignant teratoma, and one malignant teratoma-embryonal carcinoma, are reported.

3. The symptoms, diagnoses and methods of treatment of such tumors are discussed.

I wish to acknowledge my indebtedness to Dr. Harold C. Thornton, pathologist, Indianapolis, for his excellent help and review of the histological material.

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ANGINA WITH NORMAL ECG

For years physicians have wondered why some patients have typical angina pectoris with a practically normal electrocardiogram. Occasionally this electrocardiogram can be altered by having the patient exercise or breathe a mixture of gases deficient in oxygen.

At a recent meeting of the Society for Clinical Investigation, J. Sayan and colleagues reported interesting studies which throw great light on this phenomenon. They were able to measure the amount of oxygen available in exposed muscle of dog's hearts with the help of special electrodes.

They found that an acute narrowing of a coronary artery produced electrocardiographic effects similar to those which appear after actual occlusion of the artery. Evidently the somewhat ischemic muscle supplied by a narrowed artery behaves cardiographically much as does muscle in the so-called border zones in cases of actual thrombosis.

These electrocardiographic changes could be largely cleared up by having the animal breathe pure oxygen. The electric technique then showed that more oxygen was reaching the affected muscle.

These observations suggest strongly that a patient suffering from an acute myocardial infarction should be made to breathe oxygen. That would seem to be a logical procedure.

—*GP*, October, 1951.

A CASE OF WATERHOUSE-FRIDERICHSEN SYNDROME DUE TO HEMOPHILUS INFLUENZAE

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THE Waterhouse-Friderichsen syndrome is a serious, usually fatal condition resulting from hemorrhages into the adrenal glands. The picture is that of sudden collapse, shock, high fever, a petechial rash, and rapid downhill course. It occurs as a complication or as part of the picture of a fulminating septicemia. The etiological agent in the case we are reporting was an organism not generally credited with causing this syndrome, and consequently deserves emphasis.

Since 1916, when a fulminating type of cerebrospinal fever was described as the sequela to infection by the meningococcus,[1] the majority of the cases of so-called Waterhouse-Friderichsen syndrome[2,3] have been credited to this organism. The cause of this rather dramatic clinical syndrome was believed by Martland[4] to be massive invasion by the meningococcic organism. Sacks[5] reported an incidence of approximately 60 percent due to the meningococcus and the remaining 40 percent grouped under streptococcus, pneumococcus and sterile cultures. Kunstadter[6] reported the incidence of meningococcal organisms as 65 to 70 percent. In 1941 Lindsay[7] reported two cases of Waterhouse-Friderichsen syndrome which were the result of invasion by Hemophilus influenzae type 'B.' Although he agrees that the major etiological organism is the meningococcus, he suggests that the greater portion of the remaining cases are due to Hemophilus influenzae. Six years later, in 1947, Ginandes and Howard[8] described a case of Waterhouse-Friderichsen syndrome due to Hemophilus influenzae.

As more information becomes available on the specificity of the antibiotics and the sensitivity of the various organisms to these drugs it becomes increasingly important to determine the etiological organism in the shortest interval of time. This, we feel, must be emphasized repeatedly, particularly in fulminating infections where tendency to "shotgun therapy" may dull the "academic view." The following detailed report of a patient whose disease fulfills the clinical, laboratory, and pathological criteria for the Waterhouse-Friderichsen syndrome aids in focusing attention on the fact that other organisms than the meningococcus may be responsible for such an entity.

CASE REPORT

On November 25, 1949, the emergency service of the Indianapolis General Hospital received a call to the home of A. R. who was said to have been "having convulsions." Upon arrival the intern noted that the child was comatose and cyanotic with irregular respirations and cold extremities. Oxygen was administered during the trip to the hospital. The respiratory rate became much slower and it was thought that the artificial respirator was necessary.

The mother supplied the history as follows: The child had developed a mild upper respiratory infection about one week previously. The temperature was not taken but it was thought that some elevation was present and that this had persisted throughout the week. Two days prior to admission the patient refused food and since that time had taken only small amounts of milk and water. Approximately 18 hours prior to admission a slight twitching of the mouth was noted which persisted for only a "few minutes." This was apparently symmetrical. At this time the temperature was thought to be higher than on any previous occasion. On the morning of admission he felt cold to touch and was sweating profusely. His respirations were rapid and shallow. Approximately 30 minutes before admission the child suddenly became comatose and unresponsive. The skin was described as "blotchy and blue all over." Emergency service from the hospital was then requested.

The past history was noncontributory. The child had had no infectious diseases. There were no gross abnormalities in the growth and development. The patient had received no immunizations. The family history revealed that an older brother was at home with pertussis and another older brother was in another hospital with "a mouth infection."

PHYSICAL EXAMINATION

Temperature—99 rectally. Pulse—100 per minute. Respirations—8 to 10 per minute. The child was acutely ill, comatose, and obviously in extremis. The skin was mottled, cold, and moist. There was no response to painful stimuli. There was no nuchal rigidity. The eyes deviated upward. The pupils were round and equal and reacted sluggishly to light. There was no corneal reflex. There were coarse rhonchi throughout the chest while the respirations were irregular and shallow. The abdomen was soft. The liver was palpable approximately two centimeters below the costal margin in the midclavicular line. The extremities were flaccid. The deep reflexes were absent.

HOSPITAL COURSE

In view of the history and the profound shock a tentative diagnosis of a fulminating septicemia with possible acute adrenal insufficiency was made. The use of the automatic resuscitator was continued for approximately 20 minutes. One hundred and ten cubic centimeters of whole blood were given by scalp vein and a blood culture was drawn. Venesection was performed on the anterior malleolar vein and 5 percent glucose in distilled water was started. The patient received 50,000 units of penicillin and one gram of sulfadiazine immediately through the venesection. In addition to this the patient received five milligrams of desoxycorticosterone intramuscularly. In view of the extreme severity of the case a lumbar puncture was deferred at this time. The respirations became somewhat deeper and more regular during the next 30 minutes and the cyanosis decreased markedly but was not completely relieved. The oxygen flowmeter was maintained at five liters per minute.

Approximately one hour following admission the temperature was 102 rectally. The respirations were approximately 12 to 14 per minute and there was minimal cyanosis. It was decided that a lumbar puncture would be attempted at this time but as the patient's position was being adjusted respirations suddenly ceased, followed rapidly by cardiac arrest. A lumbar puncture was performed immediately.

LABORATORY WORK

Hemoglobin—11.8 gms.
Total erythrocytes—3,730,000.
Total white cells—5,700.
Spinal Fluid:
Gross appearance—slightly cloudy.
WBC 285
RBC 2,900
Differential
Polymorphonuclears—10 percent.
Lymphocytes—90 percent.
Pandy—4 plus.
Total protein—Specimen not reported.
Smear—Many gram-negative bacilli.
Culture—Gram-negative bacilli. Direct typing of the spinal fluid with H. influenzae type B antiserum revealed capsular swelling.
The blood culture was positive for gram-negative bacilli which were Hemophilus influenzae type B.

POSTMORTEM FINDINGS

The gross anatomical changes observed at the postmortem examination were in the lungs, liver, spleen, and adrenal glands. The lungs, liver and spleen were moderately congested. The right and left adrenal glands revealed gross hemorrhage throughout all layers. (See Figure 1.) The microscopic examination confirmed the massive hemorrhage into all zones of the adrenal glands. The thymus was not considered abnormal. An abdominal lymph node showed moderate hyperplasia of the germinal centers.

Figure 1



Photograph of adrenal glands showing gross hemorrhage.

DISCUSSION

As in the case reported by Ginandes and Howard[8] the clinical onset was insidious and the spinal fluid was grossly purulent. The direct smear of the spinal fluid was unusual in that the H. influenzae organisms were too numerous to count in each high power field. Banks,[9] in reviewing a large series of meningococcal infections, believed that the premeningitic bacteremia phase is present only a matter of minutes or at most a few hours. No observations regarding the time element in H. influenzae infections have been reported but the presence of such large numbers of bacteria in the spinal fluid suggests either an extremely rapid reproductive rate or a relatively long period between invasion of the meninges and onset of the fulminating symptoms.

The role of the adrenal gland in the clinical picture of the syndrome remains uncertain. Ferguson and Chapman[10] observed patients whose clinical course simulated the Waterhouse-Friderichsen syndrome and whose adrenals were devoid of hemorrhage at postmortem examination. They suggested that the overwhelming bacteremia was responsible for the clinical picture and that the adrenal hemorrhage is incidental. Swingle[11] observed adrenalectomized animals and demonstrated a lag of several days between total adrenalectomy and the appearance of symptoms of adrenal insufficiency. Swartz[12] also believes that death is not due to the lack of cortical hormones.

Despite the mounting evidence against the possibility of acute adrenal insufficiency being the cause of sudden death in the Waterhouse-Friderichsen syndrome it seems advisable to institute therapy immediately. The therapy of acute adrenal hemorrhage is outlined adequately by Soskin.[13] This includes: (1) Hormone therapy consisting of adrenal cortical extract (2 cc./KG. of body weight); (2) Hydration and regulation of acid-base balance; (3) Prevention of hypoglycemia by intravenous glucose and blood sugar levels; (4) Combating the increased bleeding tendency by ad-

ministration of vitamin K; (5) The use of antibiotics in combating the superimposed infection. The therapy of diseases due to H. influenzae has been modified several times since the favorable reports of rabbit antiserum by Alexander.[14]

Since the meningeal involvement is preceded by a septicemia it seems that in combating the infection the treatment should be similar to the plan used in treating influenzal meningitis. In 1946 Weinstein[15] felt that in spite of supposedly adequate blood levels of sulfadiazine the organisms were only inhibited. At approximately this same time the sensitivity of the organism to streptomycin was demonstrated[16] and the National Research Council recommended the use of streptomycin.[17] The dosage most commonly used is one gram per day in divided doses, regardless of weight. This may be discontinued after three days. We usually continue the streptomycin for approximately five days. The use of sulfadiazine in conjunction with streptomycin seems well established. An attempt to maintain a blood level of between 12 to 18 mgm percent is made for approximately one week after discontinuing streptomycin therapy or until approximately one week following a sterile blood culture.

Recently the use of aureomycin and chloromycetin has been reported with favorable results but we have as yet had no experience with the use of these drugs in influenzal infections.

SUMMARY

The Waterhouse-Friderichsen syndrome may be caused by other organisms than the meningococcus, and one must attempt to make the etiological diagnosis at the earliest possible time so that specific therapy may be introduced. A case of Waterhouse-Friderichsen syndrome resulting from infection with Hemophilus influenzae type B is presented. It is believed that supportive adrenal therapy should be started immediately despite the uncertainty of the exact role of adrenal hemorrhage in this syndrome.

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AN ANALYSIS OF PRESENT-DAY SURGICAL TREATMENT OF PEPTIC ULCER*

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DURING the last twenty-five years there has been increasing interest in the surgical treatment of peptic ulcer. More operative procedures have been devised and more patients have received surgical treatment than in years previous. It is still too early to come to any definite conclusions concerning the best manner of handling peptic ulcers and their complications surgically, but enough has been written at least to give one a fairly clear picture of the results of the different methods of treatment and to enable one to draw conclusions by comparison of those results.

Actually very little is known about peptic ulcer. Its etiology is still an extremely controversial subject, but its complications and its effect upon the patient are well known. The disease may take several courses. Under adequate medical treatment, an ulcer may heal entirely and leave little or no evidence of its previous existence. It is well known that some ulcer patients have a regression of symptoms spontaneously. Some of these patients remain well, while others experience recurrences seasonally. It is probably true that a fairly large number of persons have, or have had ulcers without being aware of the fact.

But the group which causes the most anxiety is that which includes the complications of peptic ulcer. An ulcer may cause bleeding, sometimes to the point of exsanguination. This bleeding may be insidious or it may be sudden and massive. The ulcer may penetrate through the wall of the gut into the pancreas or the liver, or it may rupture into the general peritoneal cavity. Occasionally the perforations are walled off and form pockets which may or may not communicate with the alimentary tract. Fistulae are sometimes formed into other portions of the digestive tract. Occasionally ulcers are multiple, and more than one may perforate. Obstruction is a serious complication of peptic ulcer, and is somewhat refractive to medical management. Pain is one of the most frequent symptoms of ulcer, and at times is most difficult to control. A large gastric ulcer may heal with scarring and, while not causing obstruction in the usual sense, may form an hourglass contracture which interferes with gastric motility. Occasionally an apparently benign ulcer turns out to be malignant and carries the patient off.

* Read before the Jackson County Medical Society Meeting, at Seymour, March 16, 1951.

PERFORATION

Surgical procedures have been devised in treatment of all of the complications of peptic ulcer. Probably the most clear-cut indication for surgical intervention is perforation. Diagnosis is sometimes easy; for example, in the case of a known ulcer patient who suddenly is stricken with severe epigastric pain which requires morphine for relief and who, in a short time, is completely prostrated and shows a shock-like picture, with abdominal rigidity. However, at times it challenges diagnosis, especially in the rare occasions when it occurs in infants. Free air within the peritoneal cavity is a great aid in diagnosis, but it does not occur in all cases.

Closure of the perforation, if done at all, should be done as soon as the diagnosis is made. The mortality rate is roughly proportional to the number of hours which have elapsed between the time of perforation and the time of closure. If closure is accomplished in the first six hours, the chances for recovery are good; if between the sixth and eighteenth hour they become progressively less; and if over that, the prognosis should be guarded. This generality is valid only if the perforation remains open and gastric contents continue to be spilled into the peritoneal cavity. (Many small perforations are sealed off in a short time.) The length of time which has elapsed between a meal and perforation and the type of food taken also play a part in varying the prognosis.

Statistically, the results obtained by conservative therapy in perforations of eighteen hours or over are probably as good or better than those in which closure was attempted. There are some authorities who advocate intubation and continuous suction for all cases of perforation instead of operative intervention, and the mortality rates based upon this type of treatment for all cases, recent perforations or old, would probably rival those in which operation was the only treatment.[1,2,3] However, operation early and conservative intubation late is still held to be the better manner of treatment.

Several ways of closure have been devised, and each has its advocates. Simple suture of the perforation has been very successful. Plugging the hole with omentum has been used with success by some. The procedure generally accepted, however, is plication, or overlapping the stomach to cover the hole. This can be done whether the ulcer occurs

in the stomach or duodenum, and causes a minimum of narrowing and obstruction. The edges of the ulcer need not be freshened as is sometimes advocated, and, indeed, troublesome bleeding may be avoided by not doing so. Omentum may be used to reinforce the closure, but is not necessary.

OBSTRUCTION

Chronic peptic ulcer causing obstruction is another indication for surgical intervention. The obstruction may be either pre- or postpyloric, but usually occurs in the proximal duodenum. In the case of an acute flare-up of a chronic ulcer, the obstruction may be temporary, caused by edema and inflammation around the ulcer. Medical treatment will help these patients, and it is possible that under proper therapy the swelling may be reduced enough to allow for the passage of gastric contents, even though the opening has been narrowed considerably due to scarring from previous activity. Each flare-up, however, leaves its mark, and it can be expected that the degree of obstruction will be greater following each episode. Complete obstruction, of course, demands surgical treatment, but it is wiser to perform the operation before complete obstruction occurs; before the patient's general physical condition becomes so poor as to make any surgical procedure an adventure.

In the case of a benign ulcer with obstruction the operation of choice is subtotal gastrectomy. The mortality rates reported by most of the clinics in which many such operations are done are below 5 percent, some even low enough to rival those recorded for cholecystectomy and appendectomy. With a proper anesthetic, a patient in fairly good general condition, a good surgical technique, and proper preoperative and postoperative care, one may expect a successful outcome and a relatively short period of morbidity.

A feeding enterostomy is sometimes necessary in order to prepare the obstructed patient for gastrectomy. It is possible with high caloric feedings through an enterostomy tube to increase the patient's weight very rapidly and at the same time to correct vitamin deficiency, raise low serum protein, and correct acid-base and water imbalance. Blood transfusions also aid in shortening the preparation period.

If for some reason gastrectomy is not considered feasible, gastroenterostomy may be done. This operation is usually reserved for older patients who it is felt could not survive gastrectomy, or in some instances for those cases in which gastrectomy is not technically possible for one reason or another. It is much easier to do and can be done in much less time, and in older patients perhaps accomplishes as much as gastrectomy, but it has long since fallen from popularity as the operation of choice routinely for all cases of obstruction.[4]

HEMORRHAGE

Bleeding peptic ulcers are now being treated by surgery much more frequently than in years past. With adequate blood replacement, these cases can be handled surgically very successfully and the mortality rate following operative treatment of massive gastric hemorrhage is relatively low. It should be emphasized, however, that surgical treatment is an adjunct to and not a substitute for intensive medical treatment. Each case of massive gastric hemorrhage is an individual problem and demands individual consideration before decision to operate is reached, and several factors must be evaluated.

The age of the patient is a factor to be considered. It can be expected that the chances for the bleeding to cease spontaneously, with or without medical treatment, are better in the younger group of people because their vessels are more resilient and they have the ability to constrict; whereas in the older group the converse is true. Less reliance should be placed upon the spontaneous cessation of bleeding in an older person whose vessels are sclerotic and incapable of constriction in order to allow the formation of a protective clot over their lumens. The tendency might be, therefore, to continue conservative treatment longer in the case of a young person than in an older one.

The severity of the hemorrhage is another factor. Obviously the decision to operate would be made faster in a case of rapidly debilitating hemorrhage than in one in which the bleeding, although clearly apparent, causes merely a slow fall in the hemoglobin. The duration and repetition of the hemorrhage also should influence the course of treatment to be followed. A patient may have several episodes of bleeding, some minor and some more severe, and each controlled under medical management, but it remains a question as to whether the next hemorrhage can be as easily stopped or if it might be massive and exsanguinating.

It is obvious, with all the variables present, that no hard and fast rule with reference to the correct manner of treatment can be made which will be applicable to all cases. However, in order to have some basis on which to work, the following criteria are suggested. If the patient is within the younger age group, not necessarily chronologically, but rather anatomically and physiologically, and, under adequate medical management, has had two or more episodes of gastric hemorrhage, no matter how slight and regardless of how little active treatment was necessary to control each episode, surgical intervention should be seriously considered. (This would apply more to bleeding from ulcers of the duodenum than to ulcers of the stomach because the factor of location of the ulcer would play a great part in determining whether surgery should be performed regardless of the factor of hemorrhage. Gastric ulcers, of course, are looked upon with much more suspicion with regard to their malignant potentialities than are duodenal ulcers.)

Severe acute hemorrhage demands rigorous medical treatment. Patients with massive hemorrhage

require sedation, strict ulcer dietary measures, oxygen and, most of all, adequate and immediate blood replacement. There is a philosophy to which many persons adhere, which advises caution in returning the blood pressure to normal or near normal because of the possibility of dislodging a clot and initiating further hemorrhage. However, it would seem that the treatment of shock due to loss of blood should be blood replacement regardless of the manner in which it was lost, and too rigid adherence to the policy of conservatism may prolong the period of shock needlessly. Therefore, it is felt that blood should be given in sufficient quantities so as to effect as soon as possible and maintain a normal or near normal blood pressure.[5,6] If the patient has received adequate medical treatment and still shows signs of bleeding after forty-eight hours, decision to operate should be made. Of course, if there is no sign of stabilization at all after rapid blood replacement, the operation should be done much sooner than forty-eight hours because there is surely active bleeding going on which cannot be expected to be controlled by conservative methods alone.

Gastrectomy is the operation of choice, and with adequate blood replacement before, during, and after surgery, the operative mortality is low. Experience has shown that attempts to control bleeding from a peptic ulcer by ligature of the bleeding vessel or suture of the ulcer bed are notoriously unsuccessful. Only too often the bleeding begins again and the patient must be returned to surgery and gastrectomy performed.

PAIN

Unrelieved pain is considered by most authorities to be an indication for surgery. However, the paucity of objective signs and the lack of information concerning the mechanism of pain and pain perception, plus individual variations in pain tolerance, combine to make true evaluation a difficult problem. In the absence of bleeding, obstruction, or perforation, the patient complaining of pain should receive rigorous and prolonged medical aid before decision to subject him to surgery is made. Special caution should be taken when the patient is of the younger age group, because remissions and periods of complete relief for several years have been observed in patients under thirty years of age who at one time were being seriously considered as candidates for operation. It is generally felt that surgical treatment for the pain of peptic ulcer should be delayed until all medical means have been exhausted, unless the common indications for surgery suddenly appear.

Gastrectomy is again the operation of choice. Gastroenterostomy with vagotomy is probably the next best procedure, but experience so far has shown that vagotomy alone has no place in the treatment of peptic ulcer.[7,8,9] It is perhaps too early to make such a statement, since not enough time has elapsed to make an honest appraisal of the effects of the operation, but it is the consensus among the majority of the reliable writers at the present time that gastrectomy gives the greatest percentage of good results with the lowest incidence of bothersome aftereffects.

GASTRIC ULCER—CARCINOMA

Gastric ulcer, because of its malignant potentialities, requires more careful clinical observation than does duodenal ulcer, especially if the ulcer occurs on the greater curvature. It may be said that if a gastric ulcer does not show definite signs of healing during two or three weeks of intensive medical treatment, surgery should be strongly considered.

The survival rate following subtotal gastrectomy for gastric carcinoma is now deplorably low. The main reason for this probably is that, due to the silent character of the disease, it has progressed further than is supposed by the time the operation is carried out. There is a trend now toward a more radical approach, and total gastrectomy is being advised even in the case of early carcinoma. In competent hands, the operative mortality compares favorably with that of subtotal gastrectomy, and it is reasonable to assume, on the basis of available data so far, that the five-year survival will be appreciably increased as more operations of this type are done. With a better knowledge of the lymphatic drainage of the stomach, it has become more and more evident that a much wider resection is necessary than previously imagined, and removal of the omentum, spleen and splenic vessels, a portion of the esophagus, the body of the pancreas, a portion of the duodenum, all available lymph nodes in the vicinity of the stomach, both intra- and retroperitoneal, along with the stomach, is being done on a much wider scale than previously.

On the other hand, the factor of morbidity following such a procedure should be considered. It is admitted, even by the advocates of total gastrectomy, that the difficulties in maintaining a satisfactory state of nutrition after such an operation constitute a serious objection, but with strict control of the diet over long periods of time, these difficulties may be overcome and the patient may be able to lead a comfortable existence.

It would seem logical, in the light of our concepts of cancer elsewhere, to assume that the smaller the lesion, the greater the chance for cure and, therefore, the more radical the procedure. Undoubtedly the present operative mortality rate incident to total gastrectomy would decrease under such a philosophy because the operation would be done on patients in better general condition. However, we must wait for at least ten years or more until enough data has been accumulated to see whether this procedure will improve the survival rate over that of the presently employed one, subtotal gastrectomy.[10]

SUBTOTAL GASTRECTOMY

From the preceding discussion, it is apparent that the operation which gives the best results in the surgical treatment of peptic ulcer is subtotal gastrectomy.[11] This implies removal of at least two-thirds, and preferably three-fourths of the stomach. A pylorectomy is not a subtotal gastrectomy and should not be in anywise construed as such, because in most instances it will not be curative; it will not remove the patient's symptoms, or prevent recurrences.[12,13]

Even considering the relatively low operative mortality and the high incidence of good results with gastrectomy, the seriousness of the procedure should not be underestimated. One of the most serious and fortunately relatively rare complications is duodenal fistula.[14,15] External duodenal fistula of the lateral type constitutes a terrible problem in management and carries a very high mortality rate. The most difficult problem is in maintenance of electrolyte balance. These patients lose chlorides so rapidly that adequate replacement is sometimes impossible. The digestive juices rapidly cause a corrosive excoriation of the skin which is hard to control. The patient's general condition is soon too poor to permit a definitive surgical approach aimed at repair of the fistula, and conservative, supportive therapy must be relied upon to sustain the patient until the fistula closes or can be closed. Parenteral feedings, continuous Levin suction, continuous external aspiration of fluid escaping through the fistula, sedation, vitamins, plus attempts at combating the skin irritation through neutralizing the excoriating effects of the digestive juice, heat cradle over the abdomen for its drying effect, et cetera, are sometimes not sufficient to sustain the patient. It is possible in some cases to do a feeding enterostomy, and this has proven life-saving in a number of cases. This may be done under local anesthesia, and once done, it provides a portal of entry for the administration of body-building proteins and carbohydrates. The digestive juices obtained by aspiration may be instilled into the catheter and utilized. After the patient's condition warrants, an attempt may be made at repair of the fistula.

Other objectionable features noted in postgastrectomy patients include loss of weight or failure to gain weight; poor appetite; necessity for adherence to strict dietary regimen; pain; nausea and vomiting; flatulence and distention; tightness, weakness, drowsiness, and palpitations coming on during or shortly following a meal; and weakness, palpitations, flushing, sweating and tremor coming on just before a meal or after missing a meal. But it should be remembered that all of these symptoms do not occur in any one patient, and that with adequate postoperative care, most of these can be minimized. Subtotal gastrectomy gives satisfactory results in over 80 percent of the cases so treated. It is doubtful if many surgical procedures carry a higher "cure" rate.[16]

It is now generally thought that peptic ulcer is a psychosomatic disorder. If this is true, perhaps surgery has no place in its treatment, but at the present time there is no alternative. It should be recognized that there are some among the ulcer patients in whom the psychic element is so strong that it can be accurately predicted no improvement will occur following operation. In these cases, operation should be reserved for lifesaving emergencies.

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CLINICAL EVALUATION OF SURITAL SODIUM* A NEW INTRAVENOUS BARBITURATE

Report of 1000 Cases†

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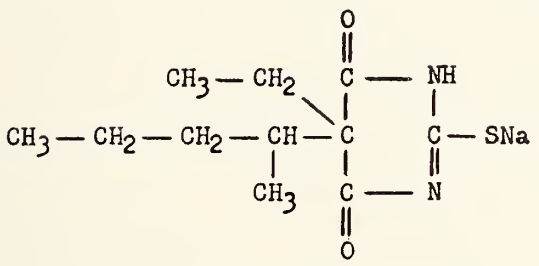
INDIANAPOLIS

SURITAL SODIUM, one of the newer thiobarbiturates, has been used to provide anesthesia for surgery in 1,000 patients. Chemically it is the sodium salt of 5-allyl-5-(1-methylbutyl)-2-thiobarbituric acid. Surital Sodium differs from Pentothal Sodium in the substitution of an allyl group for the ethyl side-chain.

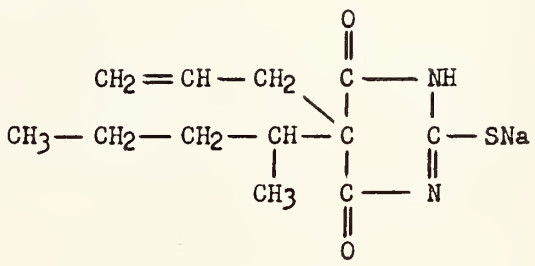
Woods et al.[3] have studied the cardiotoxic effects of these drugs in heart-lung preparations as well as in the intact animal. They have demonstrated that, in equivalent doses, Surital Sodium is definitely no more toxic than Pentothal Sodium.

Dryer has shown by chemical analysis that there is no breakdown in the ring structure of solutions of Surital Sodium which were allowed to stand for 72 hours.

FIGURE I



Pentothal Sodium



Surital Sodium

According to several investigators,[1] Surital Sodium is more potent and less stable than Pentothal Sodium. The shape and slope of the blood level curves for both drugs in dogs were found to be similar, indicating approximately equal rates of detoxification. Wyngaarden and his co-workers[2] compared the potency of Surital Sodium and Pentothal Sodium by administering each of the drugs intravenously to dogs. They found Surital Sodium to be one and one-half times more potent than Pentothal Sodium. The drug gave a more rapid induction and the animal recovered from the anesthesia quicker than after intravenous Pentothal Sodium. These workers observed that Surital Sodium accumulated at a definitely lower rate and was more rapidly detoxified than Pentothal Sodium. Studies on laryngeal reflex activity in cats showed no advantage of one drug over the other.

PRESENT STUDY

One thousand patients were observed in this study. The age of the group ranged from 3 to 89 years and the weight varied from 28 to 230 pounds. Two hundred and fourteen children under 16 years of age were included in this study. Nitrous oxide and Surital Sodium were the principal anesthetic agents in 689 patients. Metubine iodide* was used to obtain the necessary relaxation. Eight children received Surital Sodium rectally as the sole anesthetic agent. Three hundred and three patients received Surital Sodium in combination with Seconal Sodium, ethyl ether, cyclopropane, or Vinethene. The drug was used to provide hypnosis in patients under spinal and regional anesthesia.

The patients were premedicated with morphine sulfate in combination with scopolamine hydrobro-

* Supplied through the courtesy of Parke, Davis & Company, Detroit, Michigan.

† From the Department of Anesthesiology Indiana University Hospitals, Indianapolis.

* Dimethyl ether of d-tubocurarine iodide.

TABLE I

Procedure	Age Groups	Patients Receiving		Totals	Blood Pressure Depression	Reactions							Reactions to Surital-N_2O
						Resp. Depression		Laryngospasm		Nausea	Vomiting	Total No. Reactions	
		Surital N_2O	Surital in Combination			Severe	Mild	Severe	Mild				
General Surgery													
Abdominal (58)	0- 6 yrs	2	0	2	0	0	0	1	0	0	0	1	1
Hernia (17)													
Appendectomy (25)	7-15 yrs	14	3	17	1	3	0	0	0	0	0	4	1
Gallbladder (10)													
Mastectomy (14)	16-49 yrs	38	14	52	7	6	0	0	0	4	1	18	9
Thyroidectomy (7)													
Vein Ligation (5)	over 50 yrs	43	28	71	14	5	0	7	1	0	2	29	21
Incision & Drainage (6)	Totals	97	45	142	22	14	0	8	1	4	3	52	32
Surgical Specialties													
Neurosurgery (37)	0- 6 yrs	2	6	8	0	0	0	0	0	0	0	0	0
Genito-Urinary (46)													
Dental-Oral (30)	7-15 yrs	30	55	85	3	1	1	0	0	2	3	10	4
Plastic (82)	16-49 yrs	43	63	106	1	4	0	0	1	3	0	9	5
Thoracic (22)													
ENT-Eye (60)	over 50 yrs	33	45	78	11	6	0	2	0	1	0	20	16
Hemorrhoidectomy (1)	Totals	108	169	277	15	11	1	2	1	6	3	39	25
Orthopedics	0- 6 yrs	4	3	7	0	1	0	0	0	0	0	1	1
Reductions (50)	7-15 yrs	59	16	75	2	2	0	2	0	2	5	13	11
Open and Closed	16-49 yrs	21	20	41	1	0	0	0	0	0	0	1	2
Amputations (9)	over 50 yrs	30	6	36	6	2	0	0	0	0	1	9	8
General (100)	Totals	114	45	159	9	5	0	2	0	2	6	24	22
Gynecology	7-15 yrs	3	0	3	0	1	0	0	0	1	0	2	1
	16-49 yrs	271	24	295	27	13	4	3	1	7	7	62	57
Pelvic (165)	over 50 yrs	54	8	62	9	2	1	2	0	3	0	17	26
D & C (195)	Totals	328	32	360	36	16	5	5	1	11	7	81	84
Biopsies & Diagnostic Procedures													
Removal Tumors (12)													
Cystoscopy-Pyelograms (6)	7-15 yrs	6	2	8	0	1	0	2	0	0	0	3	2
Angiograms (7)	16-49 yrs	20	4	24	3	3	0	6	0	2	0	14	9
Biopsy (11)	over 50 yrs	7	0	7	2	0	0	0	0	0	0	2	2
Exam. Under Anesthesia (3)	Totals	33	6	39	5	4	0	8	0	2	0	19	13
Miscellaneous Procedures	7-15 yrs	3	0	3	0	0	0	0	0	0	0	0	0
	16-49 yrs	2	1	3	0	0	0	0	0	0	0	0	0
Closure of Wounds (6)	over 50 yrs	4	1	5	1	0	0	0	0	0	0	1	1
Debridement of Wounds (5)	Totals	9	2	11	1	0	0	0	0	0	0	1	1
Rectal Anesthesia (12)	under 1 yr	0	0	0	0	0	0	0	0	0	0	0	0
	1-5 yrs	5	4	9	0	0	0	0	0	0	0	0	0
	over 5 yrs	3	0	3	0	0	0	0	0	0	0	0	0
	Totals	8	4	12	0	0	0	0	0	0	0	0	0
Grand Totals		697	303	1000	88	50	6	25	3	25	19	216	177

mide or atropine sulfate. Children under 5 years and adults over 75 years were given atropine sulfate in preference to scopolamine hydrobromide. The dosage of morphine sulfate ranged from 3 mg. to 10 mg. and scolopamine hydrobromide or atropine sulfate from 0.15 mg. to 0.4 mg. These drugs were given hypodermically, one to one and one-half hours prior to the beginning of anesthesia. A few patients received the premedication intravenously when scheduled for emergency operation. Demerol was substituted for morphine sulfate in patients giving a history of sensitivity to the latter drug. Patients having spinal or regional anesthesia were given a barbiturate 30 minutes prior to receiving the above-mentioned premedication.

The types of operation varied widely as illustrated in Table I.

All surgical specialties were represented in this study. The anesthesia time ranged from 20 to 345 minutes. Selection of cases was made only with reference to ordinary precautions taken in the use of any barbiturate. Patients with congestive heart failure or asthma were not given this drug.

TECHNIQUE OF ADMINISTRATION

The drug was administered in a 2.5 percent solution, using the intermittent intravenous injection technique. This method was accomplished by the insertion of a three-way stopcock between the needle and intravenous tubing.

Six hundred and eighty-nine patients received 125 mg. to 250 mg. of a 2.5 percent solution of Surital Sodium intravenously for induction of anesthesia. As soon as the lid reflex was obtunded, nitrous oxide and oxygen were administered, using a circle or to-and-fro semiclosed absorption technique. The rate of flow of nitrous oxide and oxygen was maintained at 4 and 1.5 liters to 2 liters per minute, respectively. Patients requiring greater concentrations of oxygen were maintained on a mixture of 50 percent nitrous oxide and 50 percent oxygen, with the rate of flow being 3 liters per minute for each gas. Metubine iodide was used to provide the desired degree of muscular relaxation.

Seventy-seven patients were intubated after receiving Surital Sodium and metubine iodide intravenously from separate syringes. Adequate cocainization of the larynx was performed prior to anesthesia, using a spray of 10 percent cocaine. Rapid induction of anesthesia was then performed, using 250 mg. to 375 mg. of Surital Sodium. Metubine iodide, 6 mg. to 8 mg., was given to insure adequate relaxation of the mandibular and pharyngeal muscles. Oxygen under pressure was administered to provide a high alveolar oxygen concentration. An orotracheal catheter was passed through the larynx under direct vision. This technique of anesthesia and laryngoscopy required only a few minutes. It must be emphasized, however, that only one who is skilled in the technique of tracheal intubation should attempt this procedure. There is danger of severe laryngospasm and hypoxia, if the tube is not passed on the first attempt at intubation. Patients with teeth and those with a short, thick neck are not good candidates for this technique, since laryngoscopy may be difficult.

Surital Sodium was used in various combinations with other agents. A few patients were induced with the drug and maintained on ether and oxygen. Others were intubated following a cyclopropane, Vinethene, or nitrous oxide-ether induction and maintained on Surital Sodium and nitrous oxide. Some patients were intubated blindly under Seconal Sodium and maintained on Surital Sodium and nitrous oxide. If it were anticipated that the operation was to be prolonged, induction was performed with Seconal Sodium and the anesthesia maintained with Surital Sodium and nitrous oxide. Surital Sodium was given as needed by the intermittent intravenous injection to provide hypnosis for patients having spinal or regional anesthesia.

The drug was administered rectally to 12 children. Cardiac catheterization was performed in 8 of these patients with only Surital Sodium. The other 4 patients received nitrous oxide and ether in addition to the rectal Surital Sodium. The rectal dosage of the drug was calculated on the basis of 0.8 cc. to 0.9 cc. of a 2.5 percent solution per pound of body weight with the initial dose never exceeding 600 mg. Additional doses were given when adequate hypnosis did not develop.

CLINICAL RESULTS

A total of 88 patients (8.8 percent) had a blood pressure drop following the initial intravenous administration of Surital Sodium. The systolic drop varied from 10 mm. to 60 mm. Hg. The diastolic drop ranged from 10 mm. to 40 mm. Hg. This complication occurred chiefly in patients who were over 50 years of age, hypertensive, or very apprehensive. This drop in blood pressure was transient and returned to the preoperative level within a few minutes in all except 13 patients. These 13 patients responded readily to vasopressor drugs. Little or no change in pulse rate was observed with the fall in blood pressure.

Fifty-six patients (5.6 percent) developed respiratory depression which was classified as mild in 50 patients and severe in the other six. The rate of respiration was slowed, while the depth was little affected in patients having a mild respiratory depression. This complication usually occurred following the rapid injection of the initial dose of Surital Sodium or in patients too heavily premedicated. It was of short duration and very seldom required manual compression of the rebreathing bag. The 6 patients with severe respiratory

depression required reinforcement with the breathing bag to maintain proper oxygenation.

Patients intubated under Surital Sodium and metubine iodide were not included in this classification. All of these patients received large amounts of both drugs and were expected to develop respiratory depression. Most of these individuals, however, were depressed or apneic for only a few minutes and were easily oxygenated until spontaneous respirations resumed.

Laryngospasm occurred in 28 (2.8 percent) patients. This complication was classified as mild in 25 patients and severe in the other three. Laryngospasm occurred most often in very light planes of anesthesia when attempts were made to insert an oropharyngeal airway. Deepening the anesthesia, administration of metubine iodide, and positive pressure on the breathing bag were all effective measures in combating this complication.

One patient receiving Surital Sodium for hypnosis during spinal anesthesia developed a severe paroxysm of coughing, which necessitated complete anesthesia in order to finish the operation.

Eight patients developed cardiac irregularities during Surital Sodium—nitrous oxide anesthesia. One child was included in this group. Four of these patients had cardiac irregularities intermittently prior to surgery. One was a 71-year-old patient undergoing a radical mastectomy. The other three patients were healthy adults and in one of these the irregularity was definitely associated with hypoxia. Three patients receiving Surital Sodium in combination with other agents developed cardiac irregularities. One was a severely burned patient in the prone position who was hypoxic, due to technical difficulties beyond the control of the anesthesiologist. The other patients, a 12-year-old child undergoing an eye operation and a 60-year-old man having a laminectomy, developed cardiac irregularities of short duration. All the arrhythmias, except one, were transient or responded to better oxygenation. This one exception occurred in a 70-year-old woman during a hip nailing who had fibrillated intermittently prior to surgery. She was treated with pronestyl and reverted to a normal sinus rhythm.

One patient developed a cardiac arrest immediately following oral intubation with Surital Sodium and metubine iodide. This 66-year-old male had bilateral atelectasis with bowel and bowel contents in the right chest. Cardiac resuscitation was successful and the operation was quickly completed under ether-oxygen anesthesia. The patient's postoperative course was uneventful.

Vomiting during induction of anesthesia with Surital Sodium was not observed in any of the patients in this study. A few did retch or vomit while recovering from anesthesia. The incidence of this complication was higher in those who received ether or cyclopropane in addition to Surital Sodium. Excitement during induction was not seen and only three patients exhibited restlessness in the recovery period.

Six and one-half percent of the group receiving Surital Sodium and nitrous oxide anesthesia had not regained active reflexes before leaving the operating room. All children given Surital Sodium rectally were responding at the end of surgery. Eight percent of those receiving the drug in combination with ether and other agents did not respond at the completion of surgery. All other patients possessed protective reflexes and in most instances were awake and oriented. Individuals not responding at completion of surgery awakened one to five hours postoperatively.

POSTOPERATIVE COMPLICATIONS

Eight patients died following operation. Two died following repair of wound dehiscence. One developed shock during surgery which continued until death occurred 22 hours postoperatively. Congestive heart failure was the cause of death in two elderly patients. One of these vomited and aspirated gastric contents 24 hours after operation, and another died from pneumonia 6 days postoperatively. One died from a cerebral vascular accident and another from prolonged dyspnea and anoxia due to obstruction of the superior vena cava from a lung tumor. Surital Sodium was not considered a contributing factor in any of these deaths.

Twenty-five patients complained of nausea postoperatively and 17 had nausea plus vomiting. Many of these received ether or cyclopropane in addition to Surital Sodium, and many others received narcotics postoperatively for the control of pain. Only 4.1 percent receiving nitrous oxide and Surital Sodium anesthesia complained of nausea and vomiting. This complication lasted for only a few hours postoperatively. Those with severe nausea and vomiting were receiving morphine sulfate for the control of pain.

Postoperative headache was an infrequent complaint, and occurred in only two patients following general anesthesia. The headache was mild in both and was relieved with aspirin.

Pulmonary complications did not develop in any of the patients having Surital Sodium and nitrous oxide anesthesia. Postoperative atelectasis, requiring tracheobronchial aspiration, occurred in two patients following chest surgery. They were intubated after receiving Surital Sodium and metubine iodide, and the anesthesia was maintained with ether and oxygen. One person, who received Surital Sodium for hypnosis during continuous spinal anesthesia for a gastric resection, developed pulmonary edema postoperatively.

Five patients suffered circulatory collapse in the immediate postoperative period: one was due to inadequate blood replacement during surgery; one suffered a postoperative hemorrhage; one was a severely burned patient who had done poorly throughout the operation; and the other two had undergone traumatic orthopedic procedures. Suri-

tal Sodium was not considered a causative factor in any of these cases of circulatory collapse.

One patient developed a superficial thrombophlebitis at the site of injection of Surital Sodium; however, the intravenous needle was left in place for 24 hours postoperatively and this was thought to be the precipitating factor. Tissue reaction was not observed following accidental subcutaneous injection of the 2.5 percent solution of the drug.

DISCUSSION

The use of Surital Sodium in 1000 patients has been very satisfactory. It has proved to be a safe and valuable drug; however, hypotension, respiratory depression, and laryngospasm occur as with other barbituric acid derivatives.

Surital Sodium given intravenously should be supplemented with nitrous oxide-oxygen or some other inhalation agent, depending upon the type of operation and the condition of the patient. The use of nitrous oxide-oxygen with Surital Sodium definitely decreases the amount of drug needed and provides a constant, adequate supply of oxygen to the patient. In the 689 patients who received Surital Sodium and nitrous oxide alone, the average dose was 547.4 mg. and the average anesthesia time was 100.3 minutes. The use of nitrous oxide usually makes it possible to discontinue the administration of the drug long before the termination of the operation. This helps to have the patient awake or responding soon after the nitrous oxide is stopped.

Surital Sodium affords a smooth, rapid induction virtually without excitement or emesis. Anesthesia may then be maintained by any desired method or technique. It is advisable to let the patient breathe nitrous oxide-oxygen or cyclopropane-oxygen mixtures for several minutes before changing to ether anesthesia. This will reduce the incidence of cough and laryngospasm. Recovery from Surital Sodium is rapid with little restlessness, excitement, or emesis.

Surital Sodium has been given to 214 children and found to be satisfactory. The rectal administration was preferred in children under 5 years of age.

The incidence of postoperative nausea, vomiting, and headache was low with Surital Sodium-nitrous oxide anesthesia.

SUMMARY

1. Clinical experience with a new intravenous thiobarbiturate, Surital Sodium (sodium salt of 5-allyl-5-(1-methylbutyl)-2-(thiobarbituric acid), in 1000 patients is described.

2. The drug affords a smooth, rapid induction and recovery, with little postoperative discomfort to the patient.

3. The indications and contraindications of Surital Sodium parallel those of other barbiturates used in anesthesiology. The dangers and disadvantages are similar to those of other barbituric acid derivatives.

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A.M.A. CLINICAL SESSION

POSTGRADUATE study for the general practitioner is the foundation upon which the A.M.A. Clinical Session at Los Angeles next December 4 to 7 is being built.

As in previous years the scientific program and the exhibits will be beamed on the problems of general practice. This year special emphasis will be placed on therapy.

Since the subjects will be presented by specialty classification, most of the program will be of interest to specialists as well.

Practical clinical discussions, and presentations which are integrated with the scientific exhibits are included in the program. Colored television will demonstrate surgery, clinical treatment and examination procedure.

In addition to the usual sections of the scientific program, the subject of traumatology as related to civil defense will be discussed.

The exhibits and meetings will be housed in the Shrine Convention Hall and the adjacent Malaikah Temple. Twenty-one hundred lineal feet of space has been allocated for exhibits.

Interesting and diversified activities have been planned for wives accompanying their husbands. Doctors are urged to make their hotel reservations in advance.

EWING OLD AGE PLAN

OSCAR EWING'S proposal for free hospitalization for all persons who are covered by social security and who are over 65 years of age has received an adverse vote from the National Federation of Independent Business.

The Federation, which has a membership in the neighborhood of 100,000, recently completed a poll of its members and overwhelmingly voted against the socialistic scheme. Eighty-four percent of the members went on record as opposed.

The free hospitalization plan is clearly a part of the grand plan for the socialization of medical care. It has evidently been introduced on the strategy that, if the complete socialization of medicine has been refused, small segments of the plan may be introduced and accepted more easily. It is the wedge by which the master plan may be introduced and built up piece by piece.

The medical profession may expect many such wedges in the future. The socializers are patient people and one rebuff will not discourage them in the least. A multitude of attractive schemes bearing upon all aspects of medical care are no doubt in the offing. In the future the profession must be alert to multiple flank attacks.

When socialism is broken down into component parts, some of the parts will be found on super-

ficial examination to be more attractive than others. Free hospitalization for persons over 65, to an uncritical observer, will appear to be very attractive; it has a glitter to it and an emotional appeal. Only when it is considered in its true light, as a part and parcel of complete socialization of medical care, will the fallacies and dangers of it be apparent.

There is no such thing as a little socialism. Once introduced on a limited scale, socialism has always expanded into the entire economy. The only way to avoid socialism is never to have any of it.

The National Federation of Independent Business is to be congratulated for insight into the situation. They evidently feel that this apparently small wedge would spread socialism into all of medicine, and that if medicine were socialized, other professions and business would follow.

VOLUNTARY HEALTH INSURANCE

THE Health Insurance Council, made up of nine trade associations in the life and casualty fields, came up with its 1950 report last week which should set socialized medicine supporters back on their heels.

The report shows that at least half of the nation's population at the end of last year was covered by one type or other of voluntary protection against the economic hazards of sickness and accident.

All forms of voluntary health protection scored tremendous gains in 1950 to set new records.

Hospital expense protection, which covers the largest number of people, was extended to 76,961,000 persons at the close of 1950. This total was 17 percent greater than the figure of 66,044,000 just a year before.

Growing public appreciation of the advantages of voluntary health protection can be seen in the fact the number of people protected against hospital costs has more than doubled since the end of World War II.

Great strides also were made by surgical expense and medical expense coverages in 1950. Protection against surgical expense was provided to 54,477,000 persons at the end of last year as compared with 41,143,000 a year earlier, or an increase of 32 percent. A year-to-year gain of 28 percent was recorded by medical expense protection which covered 21,589,000 persons in 1950 and 16,862,000 in 1949.

Both surgical and medical coverages also have shown larger postwar gains, with the 1950 number of persons in each case being more than quadruple the 1945 totals.

The A.M.A. Council on Medical Service has received a supply of the complete insurance report and will mail it to any physician requesting it.

Secretary's Letter, A.M.A.,
September 14, 1951.

Editorial Notes

The June 1951 Civil Defense Issue of THE JOURNAL has enjoyed a lively business in the way of reprints, and has received compliments from many sources. Requests for reprints or for the entire journal vary from one to several hundred copies, and have come from all parts of the United States. One reprint has been dispatched to the Civil Defence Organization of Australia. Many civil defense units have utilized the manual for training purposes. The Marion County Civil Defense Director has also made copies available to all the major defense setups in the country. The A.M.A. Council on Emergency Medical Service has obtained several copies for study purposes. Some 2,300 reprints have been dispensed to date.

The U. S. Army Medical Department is advising a sharp lookout for cases of recurrent malaria in returned Korean Campaign veterans. All personnel in Korea are under suppressive treatment and may show the first clinical symptoms of malaria after they have returned to the United States and have discontinued suppressive drugs. The situation calls for more alertness than did similar circumstances after WW II. Almost all malaria in Korea is the tertian variety (once the endemic form in U. S.). Military personnel are released sooner after arriving home, and more of them will be seen by private physicians. Prompt recognition and treatment of the disease will aid in preventing the inoculation of mosquitoes and the propagation of the parasites.

The A.M.A. reports that its mechanical quackery exhibit at the Indiana State Fair drew unprecedented huge crowds. The exhibit was near the State Medical Association's blood pressure determination booth. Long lines of visitors waiting to have their blood pressure taken were handed the A.M.A. pamphlet "A Doctor For You," and most of them also toured the quackery exhibit.

The Price Index of the Bureau of Labor for the year 1950 indicates again, as it has in former years, that the increase in the cost of medical care is less pronounced than the increase in the general cost of living. Goods and services generally which cost $1.00 in the base period 1935-39, sold for $1.72 in 1950. In comparison $1.00 worth of medical care during the base period cost only $1.48 in 1950. Physicians' fees rose at the rate of $1.00 to $1.40, about half as fast as the total cost of living.

Medical Panorama by the Associate Editor

A LETTER TO AN EDITOR

This letter is one written by a patient to the editor of a medical journal—*The Connecticut State Medical Journal*—and contains ideas that have been expressed before, yet we feel it deserves attention from the medical profession because it contains a lesson for us. That lesson presents a fact we are apt to overlook, or, indeed, to deny,—namely, that the laity expects the doctor to do his duty and hew to the line, even though such integrity might appear to be displeasing to the patient. For a lay person to have such ideas as applied to hospitalization is both important and encouraging.

Here follows the letter:

A Hospital Patient Speaks Her Mind

To the Editor:

During my recent stay at ——— Hospital I found the service excellent, the rooms airy and comfortable, the nurses very pleasant and always cheerful, and the food delicious, attractively served and always hot or cold as the occasion called for. The nurses are definitely overworked and there is a definite need for nurses aides from 8 to 10 p. m. There should be a few floating aides on all evening to help the very sick who cannot afford special nurses.

The use of the hospital as a country club should definitely be stopped (italics-Ed.). Doctors should cooperate in this respect and not send in patients unless absolutely necessary. Doctors should discharge patients as soon as possible and not let them stay a few more days for a rest. Doctors should not send patients to the hospital for a rest. There are convalescent homes and private homes in the country that could take care of these cases.

Patients who can afford to pay for diagnosis should not be sent to the hospital until after the diagnosis seems to warrant the same. If this were done it would not be necessary for those patients really requiring surgery to wait from two to four weeks for a bed. It would also cause less hardship on the overworked understaffed and possibly underpaid nurses. Perhaps the setup of the hospitalization insurance should be changed to a broader plan. In other words, a policy that would entitle patients to outpatient diagnosis, practical nursing care if needed in their own home might prove more adequate. Hospitals should be kept available at all times for the very sick who really need special services such as intravenous, oxygen, surgery, and so forth. ——— Hospital has become so attractive that folks who want a rest are taking advantage of it.

Unless the doctors stop to consider, if I send this patient to ——— Hospital will I be taking a bed from a very sick person, possibly causing his death, we are apt to develop the situation which has developed in England. Isn't this one of the basic points of the doctor's fight against socialized medicine? The patient too must cooperate and ask himself, "Do I really need to go to the hospital or can I be adequately taken care of at home? *If I occupy a bed in ——— Hospital will I be guilty of someone's death because an operation had to be delayed while I rested in ——— Hospital?*"

Everyone is aware that emergency cases are always admitted and probably always will be. This is as it should be—your son or your daughter may need a bed in a hurry—don't tarry longer than absolutely necessary. If you do not really need to be hospitalized remember that you are making extra work and therefore are a burden to ——— Hospital.

Very truly yours,

Hannah S. Whitby.

In *Minnesota Medicine*, for August 1951, there is an editorial based partly on another editorial containing some interesting ideas about the President's "revival of the health insurance issue."

Expressing the view that Truman is feeling the need for compromise in his invitation to critics to come up "with a better proposal—or even one that is almost as good," the *Washington Post*, in a recent editorial, states it this way:

"In our view, the President minimized the gains that have been made on a voluntary basis. When the first compulsory health insurance bill was introduced in Congress in 1939, fewer than 3 million persons were enrolled in the Blue Cross hospital service plan. Today that enrollment is in excess of 40 million . . . it is now supplemented by the Blue Shield plan, sponsored by the medical profession for the prepayment of medical and surgical care, which is also growing rapidly. . . .

"The President says that 75 million Americans have no health insurance at all. Why the negative approach? If this means that the other 75 million do have some protection against the mounting costs of illness, the gain is enormous . . . we suspect that any compromise likely to be considered will have to be built on the foundations already laid."

* * * *

It seems strange that such people as Truman and Federal Security Administrator Oscar Ewing, being in such "high" places and supposedly in a position to receive all kinds of valuable information, have not yet been instructed that the American people obviously will not be compelled to buy health insurance which is controlled by a government bureau.

We fail to see why "it seems strange" that men in positions of power should continue to seek still more power, unless the entire history of mankind and his politics is "strange." It would indeed be surprising to find Mr. Oscar Ewing willing at this stage to toss in the towel and we feel strongly that the medical profession must resist the temptation to relax its vigilance just because of a lull in the battle. Don't forget the possibilities of ambush or of sneak attacks *via* the back door. Examples of the latter have already been remarked upon by this JOURNAL.

President's Page

FELLOW MEMBERS of the Indiana State Medical Association: As I assume the presidency of this grand organization, I am highly cognizant of the honor bestowed upon me, for which I wish to thank all of you.

The activities of the state association are twofold, namely, scientific and business, neither one of which can operate successfully, for the best interests of the public and physicians, without close contact with the other.

In order to facilitate smoothness of the association functions, I am privileged to request the services of some of you on various committees. While I have had an opportunity to observe the working of a number of committees in the past year, I am severely handicapped by the loss of our beloved Ray Smith.

As co-chairman of your Legislative Committee for more than ten years, and with offices in the same building as the state headquarters, I had an unusual opportunity to come in contact with Ray frequently. His innermost thoughts were of the state medical association and the relation of its members to the public. He had a most intimate knowledge of the contributions and obstacles presented by members of our association toward good public relations, which means good and considerate medical service to the public. Just a few days before his untimely passing we had gone to a meeting at Lafayette and had discussed plans to increase medical efficiency in the coming year, and had arranged to "go into a huddle" the following week. I shall miss him greatly, and the association has lost a loyal and competent executive as well as a sincere friend.

In this issue of The Journal is a list of most of the committees for the coming year. I have attempted to select men from various sections of the state, in order to have a cross section representation. I regret that I could not name each and every one of you on a committee. There is, however, one most important committee on which I would ask you all to serve. That is a committee of one to promote unity for the best American medical service.

J. William Wright



J. WILLIAM WRIGHT, M.D.
Indianapolis

PRESIDENT
INDIANA STATE MEDICAL ASSOCIATION
1951-52

J. WILLIAM WRIGHT, M.D.

President

Indiana State Medical Association

1951-52

DR. J. WILLIAM WRIGHT, SR., of Indianapolis, succeeded to the office of president of the Indiana State Medical Association on October 31, 1951. He received the president's gavel during appropriate ceremonies on the last day of the annual convention.

Doctor Wright in his speech of acceptance stressed the importance of continued vigilance on the part of the medical profession in regard to recurring attempts toward the socialization of medicine. He bespoke the cooperation and loyalty of every physician and announced that his watchword for the association was to be "Unity."

No more suitable guide could be proposed for these troubled times. With the entire world unsettled, the medical profession is fortunate to have a code to which we may adhere and by which we may solve our problems.

Doctor Wright was born on October 6, 1887, in Chatsworth, Ontario, Canada. He and his family moved to Indianapolis in 1894. He received his grade school and high school education in Indianapolis and graduated from Emmerich Manual Training Night School in 1907.

In the same year he entered medical school and received the M.D. degree from Indiana University School of Medicine in 1911.

Doctor Wright served a rotating internship at the Methodist Episcopal Hospital and then was associated with Dr. LaFayette Page as his assistant for several years. He received postgraduate training in otorhinolaryngology in clinics in New York, Philadelphia and Chicago, and in 1917 established his own office with practice limited to diseases of the ear, nose and throat. His son, Dr. J. William Wright, Jr., has been associated with him for the past three years.

He helped organize the Indianapolis Society of Ophthalmology and Otolaryngology in 1921 and served as its first president. He is a member of the Indiana Academy of Ophthalmology and Otolaryngology, American Academy of Ophthalmology and Otolaryngology, Tri-ological Society, and is a Fellow of the American College of Surgeons.

Doctor Wright's record of service to his county medical society and the state association includes many offices and committee assignments. Besides his work on many committees of the Indianapolis Medical Society, he was a member of its Council for three years and was chairman of the Council in 1944. He was president of the Indianapolis Medical Society in 1947.

In the state association he was originally a member of the Committee on Legislation and Public Policy in 1933, and has been on this committee continuously since 1937, having served as co-chairman since 1939. He has been a member of the Committee on Indiana Inter-Professional Health Council each year since 1939, and was a member of the Council on Medical Service and Public Relations in 1945 and 1946. He was also a member of the Medical and Nursing School Scholarship Committee for four years, from 1947 to 1950.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

THE DOCTOR'S INCOME

New light is cast on the earnings of doctors by a survey conducted jointly by the Department of Commerce and the American Medical Association. It shows that the average physician earns $11,058 yearly before income tax is paid. That doesn't, of course, include any unpaid bills on his books.

Because of a concentration of physicians in large cities, the doctor there earns, on the average, less than doctors in any other community size except villages of less than 2,500. Pennsylvania doctors averaged $10,047 and those in New Jersey $9,690. In New York the figure is even lower. Eight per cent of all the doctors made $25,000 or more, and 13 per cent had less than $3,000 a year net.

All of which contradicts a picture so frequently painted. Doctors with huge incomes seem the exception rather than the rule. Considering the fact that a doctor needs to spend at least four expensive and important years more in college than entrants into most other professions, the yield is not exorbitant. A bricklayer who put in as much overtime as most general practitioners would earn more.

The figures are important at this time, when a shortage of doctors is so much discussed. The incomes do a lot to explain the shortage.

—*The Sunday Bulletin,* Philadelphia, Pa.

HOOSIER DOCTORS SHOW WAY IN ANTI-SOCIALIZATION FIGHT

Physicians in Indiana apparently believe that the most effective way to beat a would-be competitor is to provide a better product.

Although we don't hear so much as formerly concerning efforts to provide a federal health service which, for all practical purposes, amounts to a socialization of medicine, the fight for continuation of the free enterprise system in the medical field is being carried forward with undiminished vigor.

For one thing, a number of Hoosier doctors have made trips to England to get a closer view of the operations of that nation's socialized medicine program. This closer view provides them with many facts and figures which assist them in their battle against such a plan in this country.

But perhaps the most important thing which the 5,000 doctors of the state are doing to combat efforts to socialize their field of endeavor, is a program of self-examination to determine what are the major complaints patients now have against the service provided.

The Indiana Medical Association has a doctor-patient grievance committee which operates with the co-operation of local medical societies. Complaints which people may have regarding the services of their physicians are brought to attention and efforts made to correct whatever the trouble may be. In effect, Hoosier doctors are saying: "Tell us just what you don't like about our service, and we'll make a sincere effort to improve it."

By and large, our Indiana doctors are providing a splendid service. They recognize, however, that there are those among them who do not measure up to the high standards of the practice from time to time—just as there must be in any field of human endeavor—either professional or non-professional. They deserve commendation for efforts to improve a service which already is excellent with very few exceptions.

As pointed out recently by Hoosier Day Columnist Frank White, "After three years of socialistic experiments British health service is short on health and low on service. It is bankrupt."

But despite the failure of the British program, there are still some in this country who have the mistaken idea that Americans would profit by such a plan. Indiana's doctors, and the vast majority of those in the rest of the United States, are doing everything they can to show that the free enterprise system is the best system in the field of medicine, just as it is in any other. They deserve our encouragement and help in their fight.

—*Shelbyville News*

News Notes

FIFTY YEAR CLUB MEMBERS

The total membership in the Fifty Year Club now stands at 333. Twenty-six physicians became new members this year. Pins and certificates were mailed to them prior to the state meeting. This year's new members are: Virgil Abel, Vallonia; Fred L. Adair, Chesterton; A. C. Bartholomew, Fort Wayne; Rose J. Buttz, Indianapolis; James W. Canaday, Indianapolis; David Joe Cummings, Brownstown; Thomas J. Dugan, Indianapolis; Roy H. Elliott, Indianapolis; Charles E. Gillespie, Seymour; Harry A. Jacobs, Indianapolis; Gardner C. Johnson, Evansville; Henry S. Leonard, Indianapolis; Claude A. Lloyd, Washington; Austin R. Logan, Petersburg; John A. MacDonald, Indianapolis; Walter McBeth, Royal Center; William J. Molloy, Muncie; Ernest E. Parker, Oxford; Samuel S. Pearlman, Lafayette; Blanchard B. Pettijohn, Indianapolis; Harry N. Swezey, Lafayette; Walter E. Thornton, Fort Wayne; Milton A. Tremain, Adams; John A. Tully, New Castle; William M. Varble, Jeffersonville; Claude H. White, Mooresville.

FEDERAL GRANTS

The following federal grants for Indiana have been announced by the Federal Security Administrator:

Institution and Researcher	Amount	Subject
Harris Shumacker, Indiana University School of Medicine, Indianapolis	$7,499	Studies of combined vascular and neurological injuries.
Felix Haurowitz, Indiana University, Bloomington	3,996	Combining groups of antibody molecules. Antibody formation.
Harry G. Day, Indiana University, Bloomington	5,994	Significance of Lipoxidase in the metabolism of carotene and vitamin A.
M. G. Mellon, Purdue University, Lafayette	6,480	Study of certain methods for the analysis of water and sewage.

The United States Civil Service Commission has announced a Medical Officer examination for filling the following positions in St. Elizabeths Hospital, Washington, D. C.: Rotating Intern, $2,200 a year; Psychiatric Resident, $3,400 to $4,200 a year; Surgical Resident, $4,200 to $4,700 a year; and General Practice Resident, $3,400 to $3,800 a year. Further information and application forms may be obtained from the U. S. Civil Service Commission, Washington 25, D. C.

AMERICAN ACADEMY OF OBSTETRICS AND GYNECOLOGY

The National Federation of Obstetric-Gynecologic Societies has reconstituted itself as The American Academy of Obstetrics and Gynecology. This action was taken at the Federation meeting held on June 13, 1951, in Atlantic City in response to the long-felt need for a national society for obstetricians and gynecologists based on individual and personal membership.

Dr. Carl P. Huber, Indianapolis, was elected to the office of president-elect.

Applications for Fellowship may be obtained from the Secretary's office, 116 South Michigan Avenue, Chicago 3, Illinois.

FELLOWSHIPS IN INDUSTRIAL MEDICINE

The U. S. Atomic Energy Commission will offer eight fellowships in industrial medicine for the 1952-53 academic year, continuing a special program begun two years ago. The program is administered for the AEC by the Atomic Energy Project of the School of Medicine and Dentistry, University of Rochester, Rochester, New York.

The purpose of the special fellowship program is to provide advanced training and on-the-job experience to men and women physicians in the field of industrial medicine, particularly in relation to the atomic energy industry.

Awards are for one year's academic training at approved institutions. After completion of this training, fellows will be eligible to apply for a second year's in-plant training at one of the major installations of the AEC. The stipend for the first year's training will be $3600, plus tuition and laboratory fees, and for the second, or in-plant, year, $5000.

The fellowships are open to citizens of the U. S. who hold an M.D. degree from an approved medical school and who have had at least one year of internship. All fellows must be investigated by the FBI and approved by the AEC before entering on their fellowships.

Applications for the 1952-53 fellowships should be submitted by January 1, 1952 to: A.E.C. Fellowships in Industrial Medicine, Atomic Energy Project, University of Rochester, School of Medicine and Dentistry, Rochester, New York, Attention: Dr. H. A. Blair.

A 1947 graduate of Indiana University School of Medicine, **Dr. Paul E. Weathers** has opened an office for general practice in Pilot Point, Texas.

Dr. Russell R. Hippensteel, of Indianapolis, has moved to Hollywood, Florida, where he has opened an office for the practice of pediatrics.

Dr. Wallace E. Miller is now associated with **Dr. Harry E. Kitterman** in the practice of orthopedics at 510 Hume Mansur Building, in Indianapolis. A 1944 graduate of Harvard University School of Medicine, Doctor Miller interned at Indianapolis General Hospital, and recently completed a residency at the Riley Hospital in Indianapolis.

Dr. Mark H. Mothersill, who has been associated with Eli Lilly & Company for twenty-one years, has opened an office for general practice at 3650 College Avenue in Indianapolis.

Dr. Robert S. Radding has opened an office in the Hermann Professional Building, in Houston, Texas, for the practice of internal medicine. He is a 1945 graduate of the University of Louisville School of Medicine.

Dr. John A. MacDonald, of Indianapolis, has retired from practice, and has moved to Interlaken, New York.

Dr. Frank C. Donaldson has opened an office at 712 Anderson Bank Building, in Anderson, for the practice of obstetrics and gynecology. A graduate of Indiana University School of Medicine in 1946, he interned at St. Elizabeth Hospital in Lafayette, and then entered the Army Medical Corps, and was stationed at William Beaumont General Hospital in El Paso, Texas, for two years. After his release from service, Doctor Donaldson was a resident in obstetrics and gynecology at St. Elizabeth Hospital in Lafayette for two years.

A native of Converse, **Dr. Donn Hunter** has opened an office in Greenfield for the general practice of medicine. He is a graduate of Indiana University School of Medicine.

Dr. H. R. Hoeger, who practiced in Brookville for seventeen years, has opened an office in Connersville, where he will specialize in otolaryngology. He recently returned from New Orleans, where he took postgraduate work at Tulane University.

Dr. J. Jerome Littell, of Indianapolis, has moved to Santa Rosa, California, where he will be chief otolaryngologist at the Santa Rosa Clinic.

Dr. Charles A. Yale has opened an office for the practice of medicine in Winamac. He is a 1949 graduate of Indiana University of Medicine.

A.M.A. WASHINGTON OFFICE NEWS

BLS Reports Medical Costs Go Up Slower Than Other Family Budget Items. The American middle-income family is paying more for almost everything—*but medical care costs are going up slower than any other major item in the family budget.* This is reported by U. S. Bureau of Labor Statistics, based on its mid-1951 survey of living costs. (To obtain trends, BLS spot-checks prices of specific categories of goods and services; a number of union wage scales are tied to this survey.) The BLS report estimates medical care and drug costs in June at 54.7 percent above the average for 1935-39. In contrast, clothing costs were up 104 percent, housefurnishings 112.5 percent, household operations 61.7 percent, recreation 68.3 percent, personal care (such as haircuts, toilet goods) 93.69 percent and transportation up 71.6 percent.

Seventy-five Percent of Korea Wounded Return To Duty. Surgeon General George Armstrong, back from Korean inspection trip, reports Army Medical Department is functioning at a high rate of efficiency and contributing to troop morale. Among his findings:

1. Out of every 100 wounded men, an average of 75 eventually return to duty, 26 without leaving Korea, 35 more without leaving Japan and 14 after hospitalization in this country.
2. Death rate of wounded has been reduced to *2.5* percent, in contrast to *4.5* percent in World War II.
3. First aid is given in almost every case within 30 minutes; the exceptions, Gen. Armstrong learned from wounded, are generally confined to situations where the aid man attached to the unit also has been killed or wounded.
4. The new drug *primaquine* gives promise of becoming the first real cure for malaria; if it stands up under extensive testing, it should end the current problem of suppressed malaria breaking out after Korean veterans reach this country. The outbreaks, Gen. Armstrong believes, are not as serious as might be because of prompt and effective detection and treatment in this country.

Last-Minute Drive For Medical Expense Deduction Fails In Senate. Despite a spirited defense of the plan on the floor, the proposal for allowing deduction of most medical expenses, including health insurance premiums, from taxable income lost out in the Senate without a record vote. (Under present law a taxpayer may deduct only that portion of his medical care expenses which exceeds five per cent of his taxable income.) The idea was proposed by *Senator Zale S. Ecton* (R.-Mont.) to the Senate Finance Committee which was considering the tax bill. The Committee rejected it as it had similar ideas in the past, but Senator Ecton nevertheless carried the argument to the floor. There *Senator Lester Hunt* (D.-Wyo.) joined with him in the futile effort to get the Senate to reverse its Finance Committee, whose recommendations generally prevail. *Senator Francis Case* (R.-S. D.) also argued for the bill, and *Senator John McClellan* (D.-Ark.), while not supporting the Ecton plan, said he favored some system for granting tax deductions for medical expenses to low income families.

The Committee staff said the proposal would mean a tax loss of $700 million a year. Chairman Walter George (D.-Ga.) of the Committee said he thought the loss would be between one and two billion dollars. However, the Senate did agree to a Committee proposal for allowing *persons over 65* to deduct most of their medical costs from taxable income. (Details of Ecton plan in Bulletin 33; provision for tax relief at age 65 in Bulletin 31.)

New Controversy Develops At Prescription Hearings. Three days of Senate hearings on the prescription bill saw settlement of one controversy and start of another. *The result is that passage at this session still is in doubt.* Opening day of the hearings, the four large industry groups announced agreement to support H.R.3298, with two amendments. To reach the compromise, National Association of Retail Druggists withdrew its demand for government-determined lists of prescription and over-the-counter drugs and lined up with American Drug Manufacturers Association, American Pharmaceutical Manufacturers Association and the Proprietary Association. The three latter groups had opposed the official lists.

However, Senator Humphrey promptly made it clear he would hold out for another change, *designed to give Food and Drug Administration authority to step in and rule on prescription and over-the-counter drugs in cases where the manufacturers and other interested parties can't agree.* He argued that with an objective definition of prescription drugs written into the law, as proposed, a final authority should be provided, one with no financial interest at stake. Later Senator Lehman also suggested something like this might be needed.

Industry and professional witnesses before the Senate Health Subcommittee disagreed, arguing that no government agency should be allowed to exercise this power. Speaking for the AMA, *Dr. Walter B. Martin* said the question of which list a drug belongs on *can best be determined by clinical experience of physicians, following laboratory tests by the manufacturers.* In the rare case when a manufacturer will not comply with decisions reached in this manner, said Dr. Martin, "Public opinion and the druggists will handle the situation, when the facts are known."

These developments leave the professional and industry groups in substantial agreement that:

1. A bill should be passed to legalize telephone prescriptions and refills, with some restrictions.

2. An objective definition of a prescription drug would be helpful if written into the law.

3. The industry and the medical profession should continue to determine whether drugs belong on the prescription or over-the-counter list; this right should not be turned over to a government agency.

But Federal Security Agency (and FDA which operates under it) *still is urging that full control over drugs be given the federal government, which would classify all drugs as either "safe" or "prescription."* However, FSA Administrator Oscar Ewing emphasized to the committee at conclusion of his testimony that he and his organization would "work under either bill." He was referring to House-approved H.R.3298, without the official lists and which now is generally supported, and S.1186, which would put FSA-FDA in charge of the drug lists.

Indiana University News Notes

Fall semester in the Indiana University School of Medicine has opened with an enrollment of approximately 430 on the Indianapolis campus and a class of 150 starting the Freshman year on the Bloomington campus.

With the opening of classes the extensive remodeling work in the Medical School Building, Clinical Building, Laboratory-Science Building and Coleman Hospital is nearing completion.

Progress in construction can be seen almost every day at the new Union-Food Service Building, situated on the Medical Center campus.

Establishment in the Indiana University Foundation of a special cancer research fund as a memorial to the late Dr. L. R. Mason of Muncie, was announced recently by Howard S. Wilcox, executive director.

Friends of Doctor Mason, who received his A.B. degree from the University in 1923 and M.D. degree in 1925, already have made several gifts in his memory to the Foundation. Doctor Mason died last July.

A postgraduate course for doctors on the "Early Detection and Management of Neoplastic Disease" was presented by the staff of the Indiana University School of Medicine on the Medical Center campus Wednesday and Thursday, September 26-27, with a limited attendance of 31 doctors enrolled.

During the course there were operative demonstrations in Surgery, Obstetrics and Gynecology; ward walks; use of x-ray and radioactive isotopes; tumor clinic; biopsy and frozen section demonstrations.

Dr. Stanley P. Reimann, professor of Oncology, Hahnemann Medical College, presented the principal address on "General Care of the Cancer Patient."

Dr. Herbert H. Siesener has been appointed to the resident staff as Resident in Cardiology. A native of St. Louis, Mo., he received his M.D. degree from the St. Louis University School of Medicine and has had residency training in cardiology.

The second class in X-ray Technology recently completed the required course of instruction and clinical experience. There were six members in the class. A new class of 18 students has been enrolled in the course which opened Monday, September 10. The course is under the supervision of Dr. John A. Campbell, chief radiologist of the Medical Center.

Appointment of Mr. Bernard Carr as Supervisor of Admitting and Outpatient Offices in the University hospitals has been announced by the Administrator's Office. Mr. Carr recently completed an administrative residency here.

Dr. George Packer Berry, dean of the Harvard University School of Medicine, was a guest of Dean John D. VanNuys recently and spent an afternoon inspecting the Medical Center.

Mrs Winifred C. Kahmann, director of the Departments of Occupational Therapy and Physical Therapy, has been elected to the executive committee of the newly organized Marion County chapter of the National Foundation for Infantile Paralysis.

Effective August 1, Dr. Harold Johantgen, former resident in Medicine and Cardiology, assumed duties as director of the newly established student-employee health service on the campus. The clinic's offices are located in the Clinical Building.

Dean Trawick H. Stubbs, of the University of Missouri School of Medicine, was a recent visitor on the Medical Center campus.

Considerable progress is being made in the steel construction work for the Union Building on the campus. Footings have been poured for the footings on the south end of the building where the swimming pool will be located. A considerable part of the equipment for the food service unit of the building has been delivered and is stored in readiness for installation when construction permits.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement of Actions and Uses and of Dosage for publication in connection with a description of Banthīne Bromide for inclusion in New and Nonofficial Remedies)

METHANTHELINE BROMIDE.—*Banthīne® Bromide (Searle)*

β-diethylmethylaminoethyl 9-xanthenecarboxylate bromide

Actions and Uses.—Methantheline bromide, a parasympatholytic agent, produces both the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastrointestinal and genitourinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degree may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

Dosage.—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial adult dose, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

G. D. SEARLE & CO.
Tablets Banthīne Bromide: 50 mg.
Ampuls Banthīne Bromide: 50 mg.

Deaths

Nettie Bainbridge Powell, M.D., of Marion, died on September 26, after an illness of six years. She was eighty-three. Following her graduation from the University of Michigan School of Medicine, in Ann Arbor, in 1892, she began her practice in Marion, where she continued to practice until illness forced her retirement. Doctor Powell was an Honorary member of the Grant County Medical Society and the Indiana State Medical Association, and a member of the American Medical Association.

James S. Simons, M.D., of Lyons, died suddenly on September 8, at the age of eighty-seven. He had been in general practice in Lyons for fifty-six years, following his graduation from the Louisville Medical College in 1894. Doctor Simons was an Honorary member of the Greene County Medical Society and the Indiana State Medical Association, and a member of the American Medical Association.

Franklin E. Hagie, MD., of Richmond, died on September 12, at the age of sixty-five. A graduate of the University of Illinois College of Medicine, in Chicago, in 1911, he began his practice in Elizabeth, Illinois, moving to Richmond in 1919. Doctor Hagie was a member of the Wayne-Union County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Walter R. Hutcheson, M.D., of Greencastle, died suddenly on September 23. He was seventy-seven years of age. He had practiced in Greencastle since 1902, having graduated from the Medical College of Indiana, in Indianapolis, in 1898. Doctor Hutcheson was an honorary member of the Putnam County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

LeRoy A. Wilson, M.D., of Michigan City, died on September 26, at the age of seventy-five. He was a graduate of the University of Illinois College of Medicine, in Chicago, in 1899. He was a former member of the LaPorte County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Harry M. Bounell, M.D., of Waynetown, died on September 28, after a brief illness. He was eighty-three years of age. He graduated from the University of Louisville School of Medicine in 1893, and began the practice of medicine at Jamestown. After two years he moved to Waynetown, where he had practiced ever since. Doctor Bounell was a veteran of World War I, and was an Honorary member of the Montgomery County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Curtis M. Bland, MD., a native of Oaktown, died on September 6 in Indianapolis, at the age of seventy-eight. Following his graduation from the Medical College of Indiana, in Indianapolis, in 1905, he practiced in Greensburg until 1912, when he moved to California. After service overseas in World War I, he located in Oaktown, where he practiced until he retired a number of years ago. Doctor Bland was a former member of the Knox County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Russell E. Cole, MD., of Muncie, died on September 16, after a long illness. He was seventy-two years of age. After graduating from the Starling Medical College, in Columbus, Ohio, in 1906, he began the practice of medicine in Mt. Summit in 1911. In 1914 he moved to Muncie, and in 1934 established the Muncie Clinical Laboratory. Doctor Cole was a member of the Delaware-Blackford County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Richard J. Dasse, M.D., of Logansport, died suddenly on September 22, at the age of sixty-four. He was a graduate of the Bennett Medical College, of Chicago, in 1912. He was resident physician at the Rockville State Tuberculosis Hospital until 1915, when he went into private practice in Indiana Harbor. In 1947 he went to the Longcliff Hospital at Logansport.

Jesse E. Nixon, M.D., of Portland, died on September 14, after an illness of four years. He was seventy-six years of age. He began his practice at Mt. Pleasant, following his graduation from the Medical College of Indiana, in Indianapolis, in 1904, later moving to Ridgeville, where he practiced until locating in Portland in 1910.

(Continued on page 1124.)



The only broad-spectrum antibiotic available in concentrated drop-dose potency, Crystalline Terramycin Hydrochloride Oral Drops provide 200 mg. per cc.; 50 mg. in each 9 drops. Indicated in a wide range of infectious diseases, Terramycin Oral Drops are miscible with most foods, milk and fruit juices, affording optimal ease and simplicity in administration.

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Deaths

(Continued from page 1122)

Mark L. Loring, M.D., of Valparaiso, died on September 11, at the age of fifty-one. He received his medical degree from the Rush Medical College in 1926, and from 1928 to 1939 he was on the surgical staff of the Presbyterian Hospital in Chicago. In 1939 he returned to Valparaiso, where he entered private practice. He was a veteran of World War II, and had been on the staff of the Parramore Hospital in Crown Point since then. Doctor Loring was a member of the Porter County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Jesse H. Briggs, M.D., of Churubusco, died on September 18, at the age of seventy. He was a 1903 graduate of Rush Medical College of Chicago, and had practiced in Churubusco since that time. He was a member of the Whitley County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

William E. Miller, M.D., of South Bend, died in Chicago on September 15 after an extended illness. He was fifty-three. He graduated from the Stritch School of Medicine of Loyola University of Chicago, in 1925, and practiced in Pennsylvania and Michigan before going to South Bend in 1931. Doctor Miller was a veteran of World War II, and was a member of the St. Joseph County Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

Frederick V. Overman, M.D., of Tipton, died on September 11, after an extended illness. He was seventy-two years of age. After graduating from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1906, he practiced in Indianapolis for more than thirty years, before returning to Tipton. Doctor Overman was a member of the Tipton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Books

CLINICAL AND ROENTGENOLOGIC EVALUATION OF THE PELVIS IN OBSTETRICS. By Howard C. Moloy, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University and Sloane Hospital for Women, 119 pages, 68 figures. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa., 1951.

This is the first of a series of monographs intended to bring to the medical profession the practical results of research in special fields of medicine. The work is particularly authentic because the author, in association with the late Dr. William Caldwell, has contributed vastly to our knowledge and modern concepts of the pelvis in obstetrics.

The classification of pelvic types and their numerous variations are described and extremely well illustrated. A portion of the book is devoted to the clinical examination of the pelvis and the mechanism of labor. The discussion of these particular topics bring out many important and useful points and is presented much more vividly and briefly than in most obstetric textbooks.

The usual roentgenological methods of pelvic examination are briefly described, and the precision stereoscopic method which was developed by Caldwell and Moloy is described in detail.

The book is cheaply prepared with a paper cover but the paper is of good grade and the photographic reproductions and diagrams are unusually clear. The text is a compact wealth of obstetric material precisely presented in 115 pages. A complete bibliography enhances the value of this small volume, which can be recommended to students, obstetricians and roentgenologists.

D. A. B.

CLINICAL PEDIATRIC UROLOGY. By Meredith Campbell, M.D., Professor of Urology, New York University Post-Graduate School. With a section on Nephritis and Allied Diseases in Infancy and Childhood by Elvira Goettsch, M.D., Associate Professor of Pediatrics and John D. Lyttle, M.D., late professor of Pediatrics, University of Southern California. 1,113 pages with 543 figures. Price $18.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa., 1951.

This book is monumental. As such it will not interest the average general practitioner except as a book for reference. For those who are interested in the urologic problems in children, however, it is an excellent textbook, a comprehensive manual for the urological resident. Every phase of clinical and pathological inquiry in pediatric urology is included. Emphasis is placed on methods of examination and diagnosis, techniques of instrumentation, the value and application of laboratory procedures, preoperative and postoperative care, operative techniques, and abnormal states as infections, trauma, calculus, neoplasms, enuresis, nephritis and allied disorders. It is well illustrated, both by many reproductions of x-rays and by appropriate case reports from the author's vast experience. Each section is closed by a large bibliography which adds to the reference value of the book.

T. M. C.

BOOKS REVIEWED

REVIEW OF PHYSIOLOGICAL CHEMISTRY. By Harold A. Harper, Ph.D., Professor of Biology (Biochemistry), University of San Francisco. Third Edition. 260 pages, with numerous illustrations and charts. Price $3.50. University Medical Publishers, P. O. Box 761, Palo Alto, California, 1951.

This book, designed by the author to "present the fundamentals of physiological chemistry" for supplementing student textbooks, is quite an acceptable production. It will interest medical students, both undergraduate and graduate, and physicians as well.

The author has presented a clear picture of the subject of physiological chemistry. The material is presented in brief paragraphs headed by subjects, and there are many helpful diagrams, charts, and structural formulae, all of which make the book highly valuable for the purpose stated.

The book has a loose-leaf plastic type of binding with a flexible back and is printed by planograph method. There is an index and table of contents and a list of reference books used in the preparation. Specific page references are omitted.

This book is recommended especially for use in reviewing this subject and as a quick reference.

C. G. C.

CLINICAL HEART DISEASE. Fourth Edition. By Samuel A. Levine, M.D., Boston, Mass. 556 pages with 192 figures. Price $7.75. W. B. Saunders Company, West Washington Square, Philadelphia 5, 1951.

Much of this enlarged new edition of a most readable and valuable textbook will seem very familiar. There is the same use of illustrative cases, expression of opinion based on personal experience and at times epigrammatic expression of ideas as before. There seems to be increased emphasis on the evaluation of the minor systolic cardiac murmurs and a recommendation that cardiac murmurs be classified into six rather than the old four groups. The author's ability to condense forcefully his clinical observation is shown in such statements as, "A thin cardiac who is short of breath is apt to be in a worse state than an obese cardiac," or "the development of moderate hypertension is a favorable sign during the course of mitral stenosis," or "there seems to be some antagonism between auricular fibrillation and angina." There are exceptions to the rule that suggested treatments have been established in his own practice in his mention of precordial injection of novocain for the pain of acute thrombosis and the fairly detailed description of treatment of hypertension by pyrogens. The section on electrocardiography has been expanded and its content is clearly presented. The clinical significance and management of arrhythmias are combined with the discussion of their respective electrocardiographic pictures. This new edition seems to this reviewer to be a "must" for those who have not had the pleasure of a previous edition and a very worth-while renewal of acquaintance for the many who have.

S. L. J.

Relationship of Stress to Autonomic Lability

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance. [1,2] Such states may involve any one of the organ systems or several at one time. [1,3] The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifesta-tions	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. 8,9,10.

1. Ebaugh, F.: Postgrad. Med. *4:* 208, 1948. 2. Wilbur, D.: J.A.M.A. *141:* 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. *42:* 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. *27:* 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. *107:* 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. *58:* 251, 1948.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

COMMITTEE ON PUBLICITY

August 3, 1951

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D., and Ray E. Smith, executive secretary.

The following "Hints on Health Columns" were approved:

Week of September 9, 1951—"Hurry-Worry Disease"
Week of September 16, 1951—"Boils"
Week of September 23, 1951—"Acoustic Trauma"
Week of September 30, 1951—"Rheumatoid Arthritis"

The following general News Releases were approved:

"Quick Action Often Prevents Crippling When Polio Strikes"
"Medics Will Check Blood Pressures at Indiana State Fair"
"Cure-all Gadgets are Still Fooling American Public"

The secretary read the reply of Doctor W. W. Bauer to the committee's request for information concerning the use of the pamphlet "Calling All Parents." The matter is to be continued to the next meeting.

Approval was given by the committee to a "guest editorial," "The Doctor and His Critic," prepared by Mr. Smith, on request of the Academy of General Practice, for publication in their publication "GP."

ELEVENTH COUNCILOR DISTRICT

More than eighty members of the Eleventh Councilor District attended the fall meeting of the district, Wednesday evening, September 19. The Wabash County Medical Society acted as host to the group, which met in the Honeywell Memorial Center in Wabash.

Following reports of officers and the Councilor, the group selected Kokomo as the site for the 1952 spring meeting, choosing the date of May 21, 1952.

The afternoon scientific program was composed of two papers. The first, on the subject "Skull Fractures and Brain Injuries," was given by Harry E. Mock, M.D., Chicago. The discussion of Doctor Mock's paper was led by Dr. Joseph B. Davis, of Marion.

The second paper was given by Wallace E. Bash, M.D., of Fort Wayne, on the subject "Care of the Premature." The discussion of Doctor Bash's paper was led by Dr. R. A. Craig of Kokomo.

During the afternoon, the members of the Auxiliary were being entertained with a Puppet Show and Tea. Mrs. John F. Mills, Wabash, was general chairman for the women's program.

During the social hour preceding the dinner, the members of the district and their wives were taken on a conducted tour of the new Honeywell Memorial Center, which has been constructed and made available to the people as a community center by the Honeywell Foundation.

The dinner speaker, John M. Kelly, Jr., Fort Wayne, former U.S. Attorney, gave a detailed description of the government in tracking down and arresting Judith Coplon and her Russian counterpart. Mr. Kelly handled prosecution of this case, and gave a review of the activities of the FBI from the time they became suspicious of Miss Coplon until the time of her arrest and trial.

J. William Wright, M.D., president-elect of the Indiana State Medical Association, and James A. Waggener, field secretary, were introduced and called upon to make a few remarks.

Officers of the district are: O. G. Brubaker, M.D., North Manchester, president; C. R. Herd, M.D., Peru, secretary-treasurer; Elton R. Clarke, M.D., Kokomo, Councilor, and E. B. Jewell, M.D., Logansport, Necrologist.

LOCAL SOCIETY REPORTS

Benton County Medical Society members held a meeting at the Benton County Country Club in Fowler on August 16. This was a dinner and business meeting, and eight members were present.

Cass County Medical Society members met at St. Joseph's Hospital in Logansport on September 21. Dr. John V. Thompson, of Indianapolis, was the guest speaker.

Floyd County Medical Society members held a meeting at the American Legion headquarters in New Albany on September 14. Fourteen members were present to hear Mr. Harry Northam, of the AAPS speak on the objectives of that organization.

Greene County Medical Society members met in Linton on September 13. Dr. A. H. Fender, of Worthington, spoke on "Modern Concepts of Peptic Ulcer Therapy." Fifteen members were present.

Howard County Medical Society members met at Kokomo on October 5, when Dr. L. W. Nehil, of Indianapolis, spoke on "Surgical Treatment of Chest Diseases." Twenty-eight members and guests were in attendance.

Vanderburgh County Medical Society members met at the Hotel McCurdy, in Evansville, on September 11. Dr. Lillian B. Mueller of Indianapolis presented a paper on "Cardiac Arrest During Anesthesia."

Another meeting was held on October 9, when Dr. L. C. Roettig of Columbus, Ohio, was the guest speaker. His subject was "The Tryptic Debridement of Necrotic Tissue."

INDIANA STATE BOARD OF HEALTH
Division of Communicable Disease Control

MONTHY REPORT—JULY 1951

Disease	July 1951	June 1951	May 1951	July 1950	July 1949
Brucellosis	1	4	0	4	5
Chickenpox	33	82	156	33	30
Conjunctivitis	2	3	9	0	0
Diphtheria	6	10	6	6	32
Dysentery, virus	21	0	0	0	0
Encephalitis	2	2	3	1	5
Erysipelas	2	0	1	0	3
Food poisoning	4	1	3	2	7
Impetigo	1	3	5	0	3
Influenza	21	23	38	0	13
Infectious hepatitis	4	13	9	1	0
Measles	132	374	645	282	167
Meningitis					
Influenzal	1	0	0	1	0
Meningoccal	1	2	2	1	2
Virus	1	0	0	0	0
Unclassified	3	5	6	1	2
Mumps	49	183	292	16	65
Pneumonia	26	52	44	25	10
Poliomyelitis	25	12	1	8	248
Rabies in animals	35	63	58	60	69
Rubella	3	41	216	1	10
Scarlet fever	26	43	102	21	25
Septic sore throat	3	8	5	1	8
Tetanus	1	1	1	0	2
Tuberculosis,					
Pulmonary	145	149	178	189	204
Other forms	9	9	7	13	18
Typhoid fever	5	2	2	1	8
Vincent's angina	1	8	1	3	1
Whooping cough	54	97	135	131	116
Psittacosis	1	1	0	0	0
Paratyphoid	1	0	0	1	0

Monthly Report—August 1951

Disease	Aug. 1951	July 1951	June 1951	Aug. 1950	Aug. 1949
Brucellosis	1	1	4	4	5
Chickenpox	5	33	82	8	11
Conjunctivitis	2	2	3	0	0
Diphtheria	2	6	10	9	39
Dysentery,					
Amebic	3	0	3	0	0
Virus	31	0	1	0	0
Unspecified	7	20	2	0	2
Erysipelas	2	2	0	0	0
Food infection	3	4	1	0	2
Impetigo	7	1	3	1	0
Influenza	33	21	23	1	37
Infectious hepatitis	6	4	20	0	0
Measles	21	132	374	17	39
Meningitis,					
Unclassified	5	3	5	1	2
Meningococcal	2	1	2	0	1
Measles	1	0	0	0	0
Mumps	24	49	183	9	14
Pneumonia	7	26	52	20	38
Poliomyelitis	81	25	12	88	351
Rabies,					
Animal	32	35	63	25	47
Human	2	0	0	0	0
Scarlet fever	12	26	43	20	20
Septic sore throat	7	3	8	2	30
Tetanus	2	1	1	1	0
Tuberculosis,					
Pulmonary	141	145	149	142	168
Other forms	6	9	9	12	15
Typhoid fever	4	5	2	16	4
Vincent's angina	3	1	8	0	4
Whooping cough	96	54	97	90	66



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BOOKS REVIEWED

HANDBOOK OF MEDICAL MANAGEMENT. Second Edition. By Milton Chatton, M.D., and Sheldon Margen, M.D., both of the University of California Medical School and Henry D. Brainerd, M.D., of Stanford University School of Medicine. 510 pages. Price $3.00. University Medical Publishers, P. O. Box 761, Palo Alto, California, 1951.

The outline form of presentation, excellent illustrations, and compact reference tables make this handbook a most useful tool to have on the office desk or automobile seat of the physician who must occasionally give emergency treatment to children. It is designed to guide the physician in what to do immediately in various situations when "on-the-spot" therapy must be administered correctly, safely and effectively.

The first section gives special reference to such conditions, among which are acute cardiac failure, pericardial effusion; acute toxic diarrhea, with treatment to maintain the body fluids, electrolytes, and nutrition; vomiting, acute surgical abdomen, foreign bodies; anuria; convulsions, head injuries, coma; diabetes; croup, laryngotracheobronchitis, asthma; drowning; poisoning; bites; burns; transfusion reactions; shock, etc. A brief clinical discussion helps the physician to know that the diagnosis is correct, but this discussion is minimal; the text is almost completely on therapy.

Another section of this book deals with the proper techniques of performing such pediatric procedures as restraint, vein puncture, cannulization for continuous intravenous medication, lavage, lumbar puncture, subdural tap, tracheotomy, areosol, and oxygen therapy.

An appendix contains tables listing the commercial sources of poisons, giving the trade names of substances, the foreign ingredient, and reference page in the text for the discussion as to therapy. Another excellent table is that of poisons generally found in household articles. A table lists the normal physical and chemical constants—blood values of importance in evaluating states of dehydration, electrolyte disturbance, acid-base balance, etc., and common variations in determinations. Conditions increasing or decreasing the normal values are indicated.

The text is completely indexed, and each chapter has references to the literature.

T. M. C.



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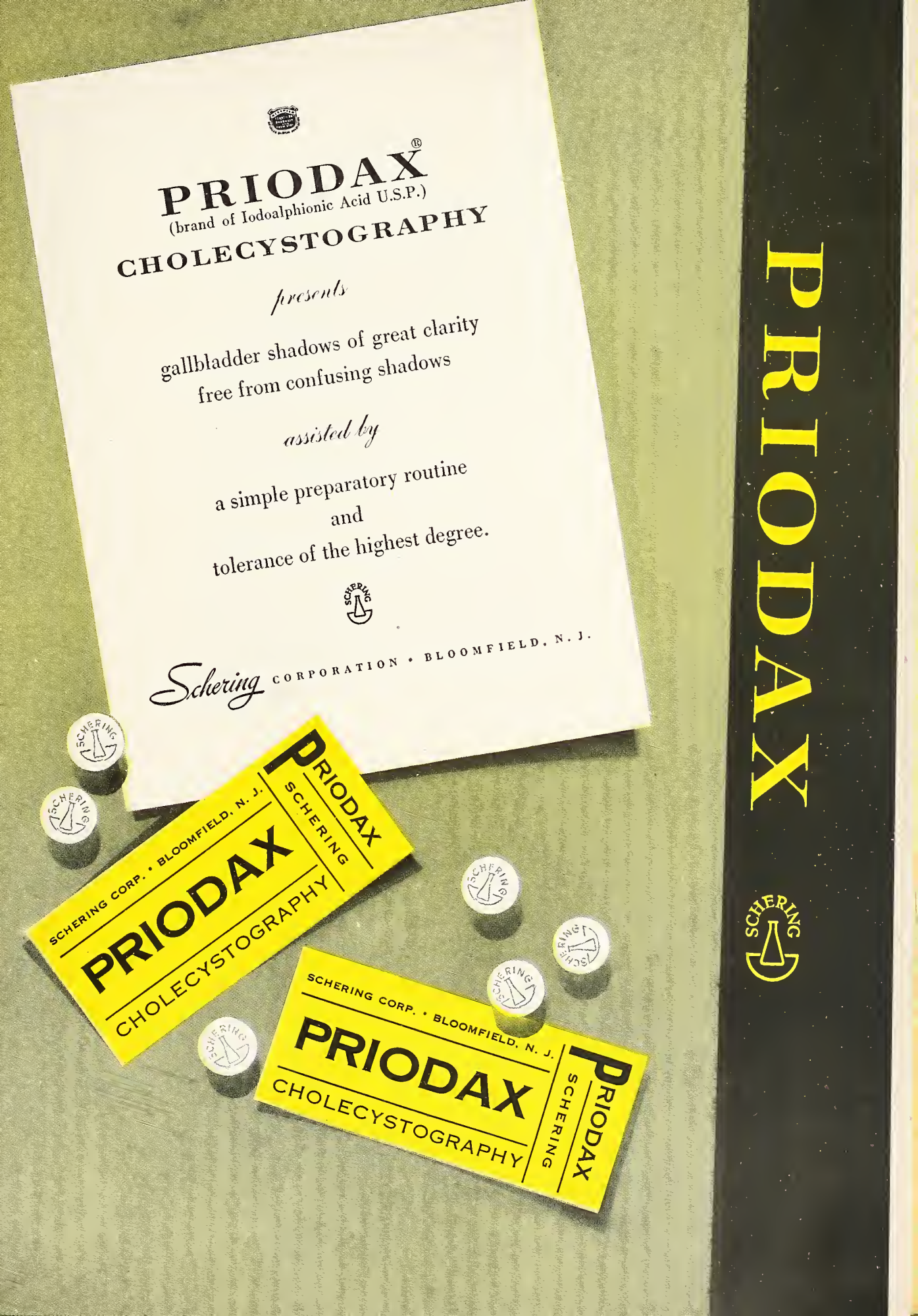
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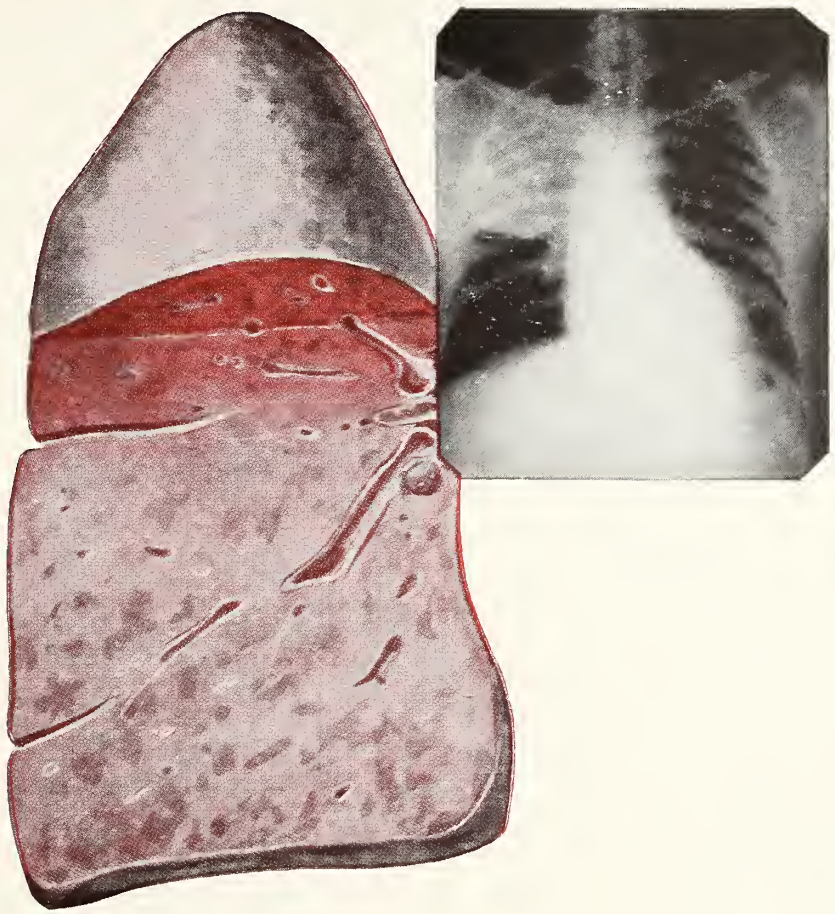
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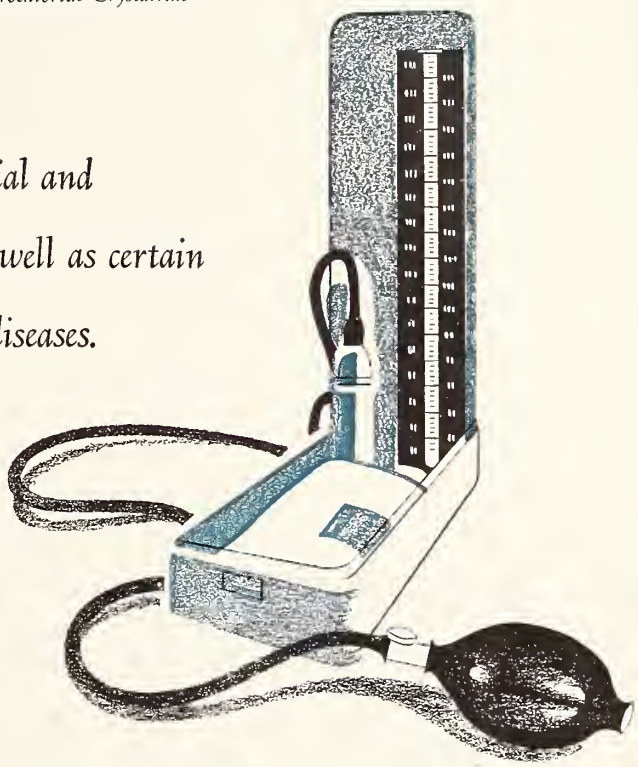
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RETROLENTAL FIBROPLASIA AND ANOXIA

CARL J. RUDOLPH, M.D.

SOUTH BEND

EDWARD M. SIRLIN, M.D.

MISHAWAKA

RETROLENTAL FIBROPLASIA was first described by Terry[1] in 1942. Observations of its development were described for the first time by Owens and Owens.[2] Its frequency is increasing. Most often it is found in premature children of three pounds or less, and in our experience a first child is more commonly affected than children coming later.

The eyes appear to be normal at birth and the condition develops between the second and fifth month of life. Both eyes are involved and blindness is usually the end result. A few cases have been reported where the condition did not develop completely and limited vision was retained, as in one of our own cases. In our case a large retinal fold exists in the right eye and the condition is completely resolved in the left eye.

The first evidence of this condition is a dilatation of the retinal vessels, especially the veins. The retina becomes edematous and hemorrhagic, and exudates form. The retina detaches and is brought forward by vitreous scars, vessels become smaller, a cyclitic exudate often forms, and soon there is a white mass behind the crystalline lens and the patient is irretrievably blind.

Many theories have been advanced as to the etiology of retrolental fibroplasia, varying from premature exposure to light, to a vitamin deficiency. Most of the theories have been proved wrong and certainly the others advanced up to the present time have not been proved correct. It is our impression that its origin is due to anoxia.

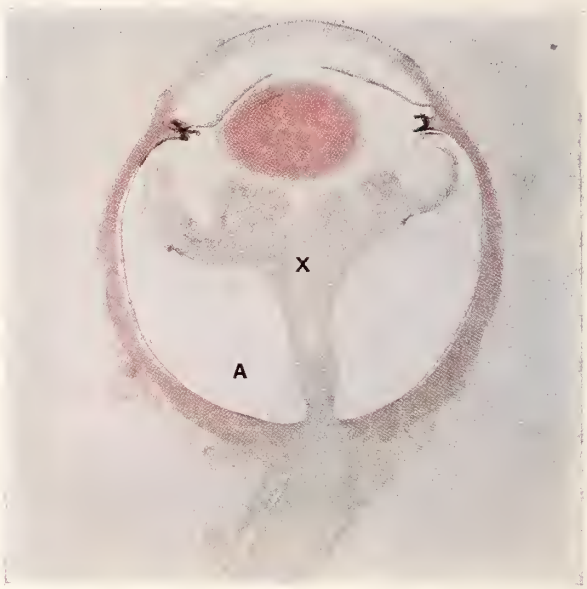
In the initial phases of anoxia we have a liquefaction of the protoplasmic substances of the vascular wall, which facilitates the passage of plasma from the blood stream accounting for the edema, later a diapedesis of the red blood cells, which is in keeping with the earliest evidences of a retrolental fibroplasia. The ensuing degenerative phenomena of a contraction of the vitreous scars and pushing forward of the crystalline lens causing a shallowing of the anterior chamber and the microphthalmus may be explained on the basis of anoxia also.

Factors predisposing to an anoxia in a premature infant are quite numerous, several are herewith enumerated: 1. Premature disruption of the maternal circulation from any cause. 2. Inability of the fetal circulatory system to carry on normally its physiologic functions because of immature development. 3. Anemia of prematurity which is more severe than in full term infants. This anemia appears to be a physiological anemia in prematures. Two of our cases showed a normachromic anemia at 25 days of 7 gm. hemoglobin and 2.5 million red cells. The reduction of the erythrocyte count and the hemoglobin level varies directly with the degree of prematurity (Zuelzer[3]). Even though this anemia appears to be physiologic in prematures, this necessarily results in a reduction of the oxygen carrying power of the blood, resulting in an anemic anoxia of the brain cells and of all the cells of the body. So the physiologic anemia of prematurity sets the stage for the development of retrolental fibroplasia according to our theory. 4. Incomplete saturation of existing hemoglobin from immaturely developed fetal lungs and respiratory controls. 5. Anoxia due to pressure on the soft and

PLATE 1



PLATE 2



X Detached retina
A Subretinal exudate

malleable head against the pelvic floor during the second stage of labor, resulting in pressure on the brain and intracranial vessels, including those going to the eyes. 6. Anoxia of the premature due to oversedation and deep anesthesia. (Faber.[4]) 7. Knee-chest position of babies sleeping with their face on the mattress may cause undue pressure on the large vessels in the neck. In addition to this the nares and mouth may be partially obstructed. 8. Frequency in premature twins where maternal circulation is divided between two fetuses. 9. The bilateral involvement suggests a systemic rather than a local involvement of the eye only. 10. Reese[5] reports vaginal bleeding in 30 to 35 percent of mothers giving birth to children developing retrolental fibroplasia. 11. Bassinettes do not encourage the circulation of air. 12. Warm temperatures in nurseries should accelerate the body metabolism and even though the oxygen ratio of the environmental air be increased this may not be sufficient to meet the requirements. 13. No tissue in the body requires as much oxygen as the nervous system. 14. It is well recognized that the brain is less able to burn fats and proteins than other parts of the body and dextrose appears to be the main metabolic substrate. With anoxia there is measurable increase in the size of the vessels, varying between 10 and 20 percent, which is more marked in the veins.[6] 15. Owens and Owens[7] have reported favorable results in treatment with d-1 alpha tocopheryl acetate, a form of vitamin E. This is not surprising in view of vitamin E's antioxidant activity. (Butt:[8] "Perhaps the most striking chemical property of the vitamins E is their antioxidant activity.") Certainly it would appear that the hothouse variety of premature infants in this country, given all the advantages known to science, is lacking in some requirement, as his foreign cousins do not share the high incidence as reported in this country. Moffott[9] could find not one paper published in England as late as December 1949 on Retrolental Fibroplasia. A few cases are now being reported.

The anoxia obviously is not an acute affair. It is an accumulative effect of several factors. Insomuch as nervous tissue is the most susceptible of all tissues to anoxia it should be expected that the retina and brain should be affected. If anoxia develops later in life the retina is affected in a different fashion. It is during the early developmental period of the infant (2 to 5 months) that such a fulminating process is capable of developing. Heath[10] states that one-half of the preschool children who are blind have this disease entity. Reversibility of process may be explained on increase of collateral circulation which when better developed could provide ample oxygen. Evidently the reversibility of the process in the brain is greater than that in the eyes, as we find more retrolental fibroplasia than those who are mentally retarded.

"Sublethal anoxia is hypothecated as a principal agent in the producton of encephalo-ophthalmic dysplasia by Ingall,[11] because of the relationships to placenta previa, antepartum hemorrhage and eclampsia." Dr. W. C. Owens of Baltimore in discussing the paper felt these were the causes of premature births rather than of retrolental fibroplasia.

We believe Doctor Ingall was thinking in the right direction; however, his causes of anoxia were minimal in comparison with those mentioned earlier

in this paper. Evidently he, the same as ourselves, noted an early mental retardation in some cases.

Stockard,[12] by controlling the temperature and/or oxidation of a fetus, in experimental animals was able to produce regularly congenital anomalies as double monsters, twins and cyclopia. This is in keeping with the hypothesis of an anoxia basis which is found in an analogous condition as peristasis and prestasis associated with angiospasm.[13] In peristasis we have a varying degree of dilatation of the vessel, a slowing of the blood stream and a liquefaction of the protoplasmic substances of the vascular wall which permits the loss of fluid resulting in edema. In prestasis the condition has progressed to the extent that there is a diapedesis of the red blood cells through the vascular wall and consequently hemorrhage. If this is so in the adult vascular system it must be doubly so in the immature walls of the fetal vessels. Angiospasm may be a contributory factor encouraging retrolental fibroplasia.

Subsequent to the edema of the retina and hemorrhages there ensues a detachment of the retina. Subjacent to the retina we find fluid and/or hemorrhages in eyes sectioned early.

Colored plates 1 and 2 show the two extremes of subretinal exudate. In plate 1 the subretinal exudate consists mostly of blood and in plate 2 the subretinal exudate is mostly of a serous character. Plate 1 is a section of one of our own cases and plate 2 is from the collection of Dr. Wendell Hughes of New York City and Hempstead, Long Island. Both were prepared by the Eno Pathological Laboratory and the Photographic Laboratory of the New York Eye and Ear Infirmary. The vessels of the choroid, if they were to liberate plasma and blood as in an anoxia, would make the detachment of the retina inevitable. Contraction of scar tissue resultant from hemorrhage and plasma into vitreous would further encourage a detachment of the retina.

A cyclitic membrane found in many histopathologic sections should be expected in anoxia of the ciliary body, a vascular layer component. An edema of the ciliary processes and the mechanics of their being pushed forward by the retrolental fibroplasia in its contracture of scar tissue make them especially prominent in this condition.

The posterior synechiae result from the third element of the vascular layer or uvea being involved, the iris. The plasmoid content of the fluid and later the hemorrhage will result in a plastic exudate-adhering posterior surface of iris to the anterior lens capsule.

Shallowing of the anterior chamber is due to pressure from behind and may lead to buphthalmus as in illustration 1, where there is a mechanical blockage of normal drainage channels.

The effect of the pituitary on respiration at the cellular level is as yet unexplained. Pituitary extract causes a contraction of the vessels and it may be a lack of this hormone which permits the uncontrolled dilatation of vessels in the early phase of the disease. Reese and Blodi[14] have reported favorable results in the treatment of retrolental fibroplasia with ACTH in fourteen cases. ACTH discourages mesenchymal proliferation.

The paucity of retrolental fibroplasia in the colored race may be related to the enlarged vessels found in these people, discouraging an anoxia.

In conclusion, we have presented many indisputable factors favoring an anoxia associated with prematurity. If this is not the prime factor in the initiation of retrolental fibroplasia certainly it must be a contributory factor of no mean proportion.

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ACUTE CYANIDE POISONING; RECOVERY WITH SODIUM THIOSULFATE THERAPY

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THE rapidly fatal action of the various cyanide salts has been demonstrated on many occasions. It is not often that a patient who has ingested cyanide is seen early enough to be aided, but, on occasion, prompt administration of the specific antidote by a physician has resulted in recovery from cyanide poisoning. Chen, Rose, and Clowes[1] report fourteen cases of acute cyanide poisoning with recovery following combined amyl nitrite, sodium nitrite, and sodium thiosulfate therapy. We wish to report a case of attempted suicide in which an amount in excess of six grams of potassium cyanide was taken. This amount is approximately twenty-five times the average adult fatal dose. Prompt administration of amyl nitrite and sodium thiosulfate resulted in rapid recovery.

Case Report: On March 6, 1951, a sixty-two-year-old white man was arrested and brought to the prison ward of the Indianapolis General Hospital. He had been arrested for morphine addiction. He had been on the ward for only a few hours when he took a small plastic vial from his rectum and poured its contents, approximately six grams of potassium cyanide, into a half filled glass of water. The patient then swallowed the contents of the glass and immediately told the police officer on the ward that he had taken "cyanide poisoning." When first seen by the physician, approximately three minutes later, the patient was unconscious, in shock, and had had one convulsion. Clear, foamy material was coming from his mouth. Within ten minutes the patient was cold and clammy, had single gasping respirations every fifteen seconds, and was cyanotic. He had no discernable pulse or blood pressure.

Within fifteen minutes after the ingestion of the potassium cyanide, the stomach was lavaged with tap water, four ampoules of amyl nitrite were given by inspiration, fifty ml. of sodium thiosulfate were given intravenously, and six ml. of Coramine were injected intramuscularly. Oxygen by nasal catheter was begun.

During the succeeding fifteen minutes, the patient's condition began to improve. His respirations increased from four to ten per minute, his color improved, and a pulse, though rapid and shallow, was felt. At the end of this time, the patient began to have generalized convulsions which continued for several minutes. A venous cutdown was then performed because of our inability to find an unsclerosed vein. A second fifty ml. of sodium thiosulfate was given intravenously and an infusion of 5 percent dextrose in water was begun.

The patient's response during the next thirty minutes was striking. At the end of one hour after the ingestion of the cyanide, the patient was fully conscious and was, in fact, requesting an injection of morphine. His subsequent course was uneventful. Six hundred thousand units of penicillin were administered daily for three days as a prophylactic measure. The patient told us later that he had been carrying the vial of cyanide in his rectum for several months in anticipation of possible arrest and consequent withdrawal from morphine.

The aspirated gastric material was examined by Dr. William Drake, Director of Laboratories at the Indianapolis General Hospital, who reported a positive test for cyanide.

SUMMARY

1. A case is reported in which approximately six grams of potassium cyanide (more than twenty-five times the average fatal dose for adults) were taken in a suicidal attempt.

2. Within three minutes the patient was unconscious and had convulsed; within ten minutes no pulse or blood pressure were obtainable and the patient was cyanotic.

3. The treatment instituted after ten minutes consisted of four ampoules of amyl nitrite by inspiration, immediate gastric lavage, fifty ml. of sodium thiosulfate given intravenously (with fifty ml. more given twenty minutes later), and supportive care in the form of oxygen and Coramine.

4. The patient made a rapid recovery.

CONCLUSION

A case of attempted suicide with potassium cyanide is reported. Prompt treatment resulted in rapid and complete recovery.

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SURVEY OF HYSTERECTOMIES*

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MUCH has appeared in the recent literature regarding the trend toward total hysterectomy, and this trend has, no doubt, been accelerated by the recognition of increasing pathology found in cervical stumps. This has prompted a recent survey of hysterectomies at the St. Elizabeth Hospital, Lafayette.

The survey represents a study of all hysterectomies at this hospital for a period of sixty-four months, from January 1, 1945 to May 1, 1950. A total of 580 hysterectomies were performed during this period of time. The type of hysterectomy is noted as follows:

Total Number of Hysterectomies	580	
Abdominal Subtotal Hysterectomies	288	(49.5%)
Abdominal Total Hysterectomies	245	(42.3%)
Vaginal Hysterectomies	47	(8.2%)

The following chart and graph show the breakdown in types of hysterectomies during this period of time, and demonstrates the trend toward complete removal of the cervix by either the abdominal or vaginal route.

Year	1945	1946	1947
Subtotal	41 (70%)	74 (77%)	69 (65%)
Total	14 (24%)	16 (17%)	32 (31%)
Vaginal	3 (6%)	5 (6%)	3 (4%)
	58	95	104

Year	1948	1949	1950 (4 mos.)
Subtotal	63 (45%)	31 (23%)	11 (22%)
Total	68 (49%)	86 (64%)	28 (56%)
Vaginal	7 (6%)	18 (13%)	11 (22%)
	138	135	50

There were three operative deaths in this series of cases with an operative mortality of 0.52 percent. Two of these deaths occurred in the subtotal hysterectomy group. One death occurred in the vaginal hysterectomy group, and there were no deaths in the total hysterectomy group.

Postoperative morbidity, based only upon postoperative temperature elevations over 100.4 degrees F. orally, on any two consecutive postoperative days other than the first postoperative day, is represented in the following chart:

Type of Operation	Number of Patients Morbid	
Subtotal Hysterectomy	63	(22%)
Total Hysterectomy	67	(28%)
Vaginal Hysterectomy	18	(39%)

The average number of days that the patient stayed in the hospital after operation was 10.2 days for the subtotal group, 12.2 days for the total group and 11.5 days for the vaginal group. Breaking this down into postoperative days in the hospital for each year, the gradual decrease in postoperative days for all types of hysterectomy is noted in the following chart and graph.

	Average Postoperative Hospital Days		
Type of Operation	1945	1946	1947
Subtotal Hysterectomy	13.7	12.7	11.1
Total Hysterectomy	20.0	12.0	10.7
Vaginal Hysterectomy	13.0	15.0	11.0

	Average Postoperative Hospital Days		
Type of Operation	1948	1949	1950 (4 mos.)
Subtotal Hysterectomy	11.5	8.7	9.7
Total Hysterectomy	10.4	9.1	10.1
Vaginal Hysterectomy	10.1	10.1	9.5

The various age groupings according to the type of hysterectomy are noted in the following chart.

Age	Subtotal	Total	Vaginal
Under 25	2 (0.7%)	5 (2 %)	1 (2.2%)
25-35	35 (12 %)	48 (19 %)	6 (12.7%)
35-45	130 (45 %)	81 (33.5%)	8 (17.0%)
45-55	100 (35 %)	80 (33 %)	12 (25.5%)
55-65	20 (7 %)	25 (10 %)	10 (21.3%)
Over 65	1 (0.3%)	6 (2.5%)	10 (21.3%)

The final diagnosis, both clinical and pathological, was recorded in each case, and the following chart is a tabulation of these diagnoses:

1. Leiomyofibroma	263
2. Cervicitis, Chronic	60
3. Ovarian Cyst, Benign	60
4. Salpingitis, P.I.D.	55
5. Uterine Prolapse	47
6. Endometriosis	32
7. Endometrial Hyperplasia	30
8. Endometrial Carcinoma	29
9. Cystocele-Rectocele	26
10. Endometrial Polyp	22
11. Carcinoma of the Cervix	12
12. Carcinoma of the Ovary	10
13. Cervical Polyp	4

* From the department of Obstetrics and Gynecology, St. Elizabeth Hospital, Lafayette, Indiana.

14. Tubal Pregnancy	4
15. Retroversion	4
16. Endometritis	4
17. Ruptured Uterus	3
18. Missed Abortion	1
19. Bicornuate Uterus	1
20. Inversion of Uterus	1
21. Weak Section Scar	1
22. Couvelaire Uterus	1
23. Hydaditiform Mole	1
24. Fibroma of Cervix	1

Of the 288 patients who had subtotal hysterectomies in this group, only two have been readmitted to this hospital with a diagnosis of carcinoma of the cervical stump. Unfortunately, there is no accurate method of determining the actual incidence of stump carcinoma in this group, as the vast majority of the patients are private patients and postoperative checkups and admissions to other hospitals are not recorded on the chart. It is also obviously impossible to estimate the number of patients from this group that may develop a malignancy of the cervical stump in the future. However, in an attempt to correlate cervical stump carcinoma, an analysis was made of all patients admitted to St. Elizabeth Hospital during this same period of time (January 1, 1945 to May 1, 1950) with the diagnosis of carcinoma of the cervix. This survey is shown in the following chart.

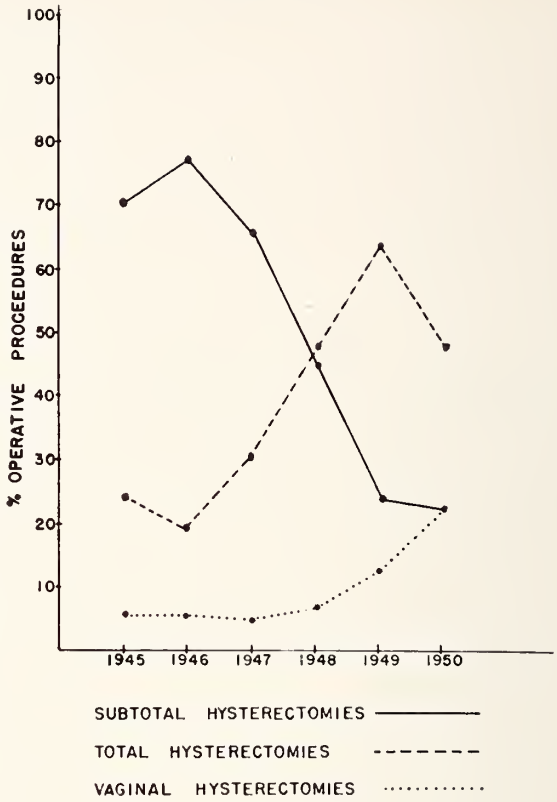
Year	Carcinoma of Cervix	Carcinoma of Stump
1945	22	3
1946	15	1
1947	12	3
1948	19	1
1949	14	2
1950 (4 Mos.)	6	2
TOTAL	88	12 (13.6%)

DISCUSSION

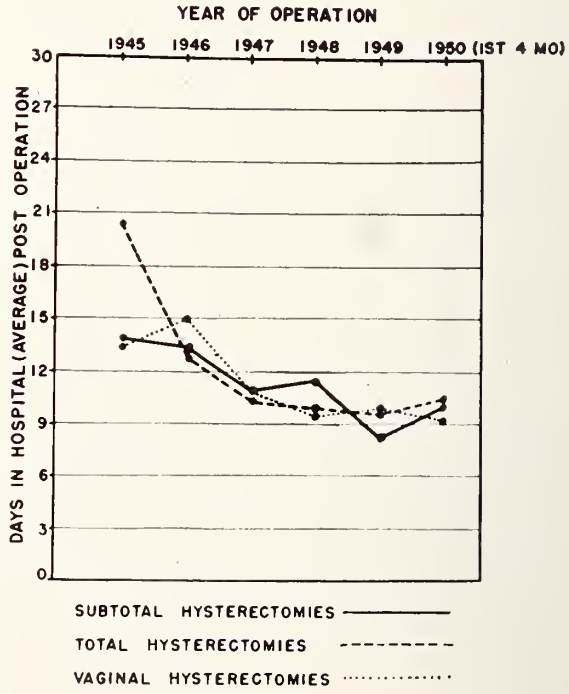
The removal of the cervix at the time of hysterectomy is, of course, a prophylactic measure against future pathology in the cervix, both malignant and benign. The incidence of carcinoma of the cervical stump varies greatly in reports from different clinics. Ward[1] reports that he found carcinoma of the cervical stump in 3.64 percent of patients with previous subtotal hysterectomies. TeLinde[2] reported an incidence of 3 percent cervical stump carcinoma at the Johns Hopkins hospital. Scheffey,[3] on the other hand, found the incidence of cervical stump carcinoma in his clinic to be only 0.9 percent. In this series only two patients have returned to our hospital with carcinoma of the cervical stump, an incidence of 0.69 percent; however, it is probable that a certain number will develop malignancy of the cervical stump in the future, and increase this incidence.

Benign lesions of the cervical stump certainly occur in a much higher incidence than do the malignant lesions and may give rise to symptoms requiring removal of the stump. Crawford,[4] in New Orleans, reports 123 patients readmitted to the

GRAPH NO. 1



GRAPH NO. 2



Charity Hospital after subtotal hysterectomy and one-third of these patients were readmitted with the same complaints for which the subtotal operation had been performed. In all of these cases the cervical stump was removed, and 88 percent of these patients were relieved of pelvic symptoms after this second operation.

Total hysterectomy by the trained operator does not carry any higher morbidity or mortality rate than does the subtotal operation. In this series two deaths occurred in patients who had had the subtotal operation, and one death occurred in a patient who had had a vaginal hysterectomy. There were no deaths in the group who had total abdominal hysterectomy.

Total hysterectomy in this series carried a slightly higher postoperative morbidity rate (28 percent) than did the subtotal operation (22 percent). The high incidence of morbidity in vaginal hysterectomy (39 percent) has been reduced in the last two years of the report to less than that of the abdominal operation by improved surgical technique and more adequate preoperative preparation of the patient. By comparison, Wier,[5] at Western Reserve, reports morbidity rates of 21 percent in subtotal hysterectomies, 20 percent in total hysterectomies, and 30 percent in vaginal hysterectomies in a series of 1,771 cases.

Objections have been raised against the total hysterectomy because of an increased incidence of prolapse of the vaginal vault and shortening of the vagina after the operation. Recent investigation, however, has refuted these objections and these complications need not occur if proper technique is used by the operator in removing the cervix and supporting the vaginal cuff. Bickel[6] reported sixteen cases of prolapse of the vagina, postoperatively, and all occurred in patients having had previous subtotal hysterectomies. McKinnon and Counseller[7] reported twenty-six cases of prolapse of the vaginal vault after hysterectomy, and only one of these followed total hysterectomy.

SUMMARY

1. A review of all hysterectomies at the St. Elizabeth Hospital is reported, representing 580 operations over a period of sixty-four months, from January 1, 1945 to May 1, 1950.
2. The trend toward removal of the cervix is noted, either by the abdominal or vaginal route.
3. The postoperative mortality and morbidity in each operation is compared along with the number of postoperative days following each type of operation.
4. The final diagnosis, both clinical and pathological, is reported.
5. A review of all cases of carcinoma of the cervix at the same hospital during the same period of time is reported, along with the incidence of cervical stump carcinoma in this group.

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Freedom of Education.—Freedom of education is the foundation upon which all other freedoms are erected, for education shapes the processes of thought. Thinking cannot remain unfettered if its sources and the methods of its teaching are controlled by the Federal Government. Local self-government in education and local responsibility for its support are two of the most priceless of American heritages and are the key to the maintenance of our system of government.—J. S. Speed, M.D., Federal Subsidization of Medical Education. *Journal of Bone and Joint Surgery*, July, 1951.

OBSERVATIONS ON USES AND DANGERS OF CATION EXCHANGE RESINS*

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IN 1946 Dock[1] suggested that a resin, heretofore used only commercially, could be modified so as to prove useful in the management of clinical syndromes characterized by edema. He showed by feeding a cation exchange resin to rats that the positively charged cation, sodium, bound by the resin in the gastrointestinal tract, was subsequently carried out by the resin in the feces. The experimental and clinical experiences of many investigators using either sulfonic or carboxylic types of cation exchange resins have recently been adequately reviewed by Dock[2] and co-workers[3] and will not be repeated at this time. The present commercial availability of cation exchange resins suggests the need for a summary of the advantages, disadvantages, and hazards in the use of present-day resins in the management of patients. Undoubtedly wider experience and development of newer resins in the future will force a change in some of these views.

Edema may be due to any of several factors. These include hypoproteinemia, increased capillary permeability, venous or lymphatic congestion, and sodium retention. Since cation exchange resins remove mainly sodium and potassium from the body, they are of value only in the treatment of the edema of sodium retention. Fortunately, the majority of edemas encountered clinically, such as the edema of chronic congestive heart failure and cirrhosis of the liver, are thought to be mainly due to abnormal sodium retention.

Sodium depletion has been widely attempted as a means of controlling edema and also to lower blood pressure in arterial hypertension. The most effective means of sodium depletion have been the use of a diet containing less than 800 mg. of sodium per day, and the use of mercurial diuretics to diminish tubular reabsorption of sodium. Rigid dietary control is unpleasant and the use of mercurial diuretics is annoying and occasionally accompanied by dangerous reactions. The new concept of increasing sodium excretion in the feces by use of cation exchange resins may give the physician a more readily acceptable means of sodium control.

There are at present three types of commercially available cation exchange resins.‡ All are of the carboxylic type but one is combined with an anion exchanger. The first available resin was a mixture of ammonium (80 percent) and potassium cycle (20 percent) resins (Resodec). Soon thereafter a mixture of hydrogen (80 percent) and potassium (20 percent) cycle resins (Natrinil) was marketed. Recently a resin has become available which is approximately 12 percent anion exchanger, 29 percent potassium cycle and 59 percent hydrogen cycle cation exchange resin (Carbo-resin). The purpose of the addition of potassium cycle in all the resins is to prevent potassium depletion secondary to the increased fecal excretion of potassium. In general this procedure has been satisfactory. The addition of an anion exchange in the one resin is an attempt to minimize the acidosis which occurs with any type of resin used.

All resins are administered in essentially the same dosage, which is adjusted to the patient. The resins are given in water, milk, or fruit juice in equally divided doses at 10:00 A.M., 3:00 P.M. and at bedtime, to a total of 40 to 60 gms. per day. The patient's preference, as to taste, may be the deciding factor in the selection of the particular resin used. In general it seems that the hydrogen cycle resins are best tolerated.

The cation exchange resins all have some undesirable features. Those include acidosis, gastrointestinal irritation, a tendency to cause fecal impaction, depletion of potassium and calcium, and the possibility of overdepletion of sodium. Careful choice of resin, frequent examination of the patient, and the use of careful laboratory controls can minimize those features.

The indications for cation exchange resins are summarized in Table I.

TABLE I

INDICATIONS FOR USE OF CATION EXCHANGE RESINS

(a) Excellent Results:
  (1) Chronic congestive heart failure,
  (2) Cirrhosis of liver with ascites and edema,
  (3) Agent to potentiate mercurial diuretics.

(b) Good Results:
  (1) Toxemia of pregnancy,
  (2) Hypertension.

(c) Fair Results (possibly contraindicated):
  (1) Nephrosis,
  (2) Renal failure.

* Presented at Third Councilor District Meeting, Silvercrest Hospital, New Albany, Indiana, May 23, 1951.

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‡ Supplies of cation exchange resins were generously supplied by Smith, Kline and French Company, Philadelphia, National Drug Company, Philadelphia, and Eli Lilly and Company, Indianapolis.

All presently available cation exchange resins have inherent in their action certain potential hazards to the patient. These may become of great significance if certain warning clinical symptoms and laboratory findings are neglected or ignored. These are summarized in Table II.

TABLE II

DANGERS IN USE OF CATION EXCHANGE RESINS

(a) Acidosis:
Warning signs:

Clinical
1. Presence of renal disease,
2. Symptoms of apathy, anorexia, or air hunger.

Laboratory
1. Fall in serum carbon dioxide capacity (below 45 vol. %),
2. Rise in serum chlorides (above 630 mg. NaCl/100 cc. or 105 mEq/1.).

(b) Depletion of Potassium:
Warning signs:

Clinical
1. Symptoms of muscle weakness, paralysis, or abdominal distention.

Laboratory
1. Fall in serum potassium level (below 14 mg./100 cc. or 4mEq/1),
2. EKG changes—low broad T waves, prolonged Q-T interval—deep U wave.

(c) Low Salt Syndrome:
Warning signs:

Clinical
1. Decreased urinary output,
2. Anorexia, lethargy, nausea and vomiting, muscle cramps.

Laboratory
1. Rise in N. P. N. (above 40 mg./100 cc.),
2. Fall in serum levels of sodium (below 300 mg./100 cc. or 133 mEq/1.),
3. Fall in serum levels of chloride (below 550 mg. NaCl/100 cc. or 98 mEq/1.).

(d) Potential Dangers:
(a) Hyperpotassemia (if Potassium cycle resin used),
(b) Vitamin depletion,
(c) Digitalis intoxication,
(d) Calcium depletion.

It is suggested that the physician use a basic plan of laboratory control in all patients in order to insure maximum effectiveness and safety in the use of cation exchange resins. This plan can then be modified to meet the changing clinical status.

The use of cation exchange resins in cardiac disease usually requires a simple type of study. It is suggested that the determination of daily weight be used to insure adequate dosage. Determination of serum carbon dioxide content or combining power and serum chloride will usually give adequate warning of approaching acidosis or sodium depletion in patients who are eating an adequate diet.

The presence of renal disease requires much more careful study of the patient. In our opinion there should include daily weight and determination of 24-hour urinary output. Biochemical studies should include frequent determination of serum sodium, potassium, chloride and carbon dioxide content or combining power. We have used the electrocardiogram as a screening method for the determination of potassium deviations.

DISCUSSION

Cation exchange resin mixtures are an effective clinical means to achieve sodium depletion in edematous and hypertensive patients. However, these agents are not without danger and require careful clinical and laboratory study of the patients undergoing treatment. In a series of patients treated with various resins, we have had examples of gastric irritation, fecal impactions, severe acidosis and marked depletion of sodium and potassium.

It seems likely that the present-day management of patients with congestive heart failure will include digitalis, modified dietary sodium restriction and the use of cation exchange resins. Mercurial diuretics can then be used as needed to achieve and maintain a "dry" weight.

Cirrhosis of the liver with ascites and edema has responded in a satisfactory manner to a high protein diet, cation exchange resins, vitamin supplements and infrequent use of mercurial diuretics.

Cation exchange resins are difficult to use in the presence of renal disease. However, if edema is incapacitating, resins may be safer than mercurial diuretics. In our experience the use of the anion-cation exchange mixture has seemed to delay the development of severe acidosis in patients with renal disease.

CONCLUSIONS

1. Cation exchange resins are useful agents in the treatment of edema secondary to sodium retention.
2. Disadvantages of cation exchange resin therapy include gastric irritation, fecal impactions, development of severe acidosis and excessive depletion of sodium and potassium.
3. A plan for the clinical and laboratory study of patients undergoing cation exchange resin therapy is presented.

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MODERN DEVELOPMENTS IN THE SURGICAL TREATMENT OF PEPTIC ULCER*

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CHICAGO

THE presence of ulcerative lesions in the stomach and duodenum as a cause of digestive disturbances has been known since the earliest times, yet it was not until Jean Cruveilhier's[1] description of round ulcer (1829) that the ulcer problem occupied medical minds in any clear-cut way. Most of the knowledge in the early half of the 19th century and even later came from the deadhouse, clinical medicine dealing chiefly with complications such as hemorrhage, obstruction, and perforation.

Rudolf Virchow (1853)[2] offered the earliest plausible theory as to etiology, his view being that the ulcer process results from the plugging of the nutrient artery of the part by embolus or thrombus, and the infarct so produced is destroyed by the digestive action of the gastric juices.

Letulle,[3] the French pathologist, in the 1880's advanced the idea that the ulcerative process is due to bacterial focal necrosis of the gastric mucosa. The science of bacteriology in its infancy was called upon frequently to explain unsolved problems in medicine.

As the old century drew to a close, the pendulum of interest swung irregularly back and forth between the medical and surgical aspects of the disease. Thus surgery took the forefront when Billroth, in 1881, performed the first successful stomach resection. It is true that Billroth's operation was done for cancer, yet it provided new possibilities in the treatment of benign lesions of the stomach and duodenum. Pean in France and Rydygier in Germany had performed similar operations in 1879, but their patients died.[4] Wölfler, a member of Billroth's clinic, in 1881 did the first recorded gastroenterostomy—incidentally, it was an anterior operation—for pyloric stenosis. Since gastroenterostomy was destined for many years to be the definitive operation for ulcer, the year 1881 may be said to have marked the beginning of an era in gastroduodenal surgery.[5]

Stimulated by the work of the Billroth clinic numerous operative procedures for ulcer and its complications were devised in the succeeding years well up into the present century. Postoperative complications, recurrence rate and operative mortality were high. Thus the death rate for so simple a procedure as gastroenterostomy, from 1881 to 1885, was said to have been as much as 65 percent (Mayo-Robson).[6]

Because of this, medical giants of the day, Kussmaul, Ewald, Dieulafoy and others, busied themselves anew with the development of nonsurgical methods of treatment: rest (rectal feeding), gastric lavage, astringent irrigations, antispasmodic drugs and diet. The pendulum veered toward conservative management. Lavage was emphasized and there were many heated controversies concerning its indications and contraindications. Textbook teaching was against lavage in the presence of hemorrhage, but the "name" gastrologists,[7] especially Kussmaul, v. Leube, Ewald and Einhorn, championed the use of the tube, even in bleeding and otherwise active ulcers.

Necessary recourse to surgery in emergency and intractable cases led to continued improvements, and to the development of pyloroplasties, gastrostomies, gastroduodenostomies, gastrogastrostomies (for hourglass stomach) and pylorectomies of different types, including so-called "sleeve resections," published under the names of Wölfler, Heinecke-Mikulicz, v. Hacker, Jaboulay, Roux, Finney, Berg, and many others.[8]

Exclusion operations (Doyen,[9] v. Eiselsberg,[10] Finsterer,[11] Devine[12]) developed on the principle of shunting the acid gastric contents away from the lesion, thus favoring healing, were frankly unphysiological. This was because of failure to realize that remnant antral mucosa invites recurrence. The vogue of these operations, properly, was shortlived.

Surgeons of continental Europe early in the century were employing partial gastrectomy for both duodenal and gastric ulcers, but it was not until about 1925 that American surgeons, led by Berg[13] of New York, and Alfred Strauss[14] of Chicago, began to use this operation generally for peptic ulcer instead of gastroenterostomy.* Coincidentally, the latter operation was losing popularity for reasons mentioned in a later paragraph.

In the first decade or two of the present century, surgery was in the ascendancy in spite of short-

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* Hans Finsterer of Vienna must be credited with furthering the employment of gastric resection in America, when he made a personal tour of this country about 1925. The author was present on occasions when he demonstrated and supervised members of the surgical staff of Cook County Hospital in his method of performing gastric resections under local and splanchnic anesthesia. Later on in 1926, the author spent the month of February viewing at close range the work of this master. It may also be mentioned here that Finsterer was a protagonist of radical surgery for severe gastric hemorrhage. (See also H. Finsterer, Lancet 2:1220, 1935.)

comings. Impetus to more rational surgery of gastroduodenal lesions followed the advent of the roentgen ray with contrast media for gastroenterologic diagnosis.

The observation that the greatest benefits following gastroenterostomy were obtained in cases of pyloric obstruction led to the employment of the fallacious pyloric exclusion procedures as adjunct to gastroenterostomy in nonobstructive cases. In this connection, a number of methods were devised to produce pyloric obstruction when it did not exist.

Meanwhile, the Sippy Treatment[15] was being developed. The introduction of this well-known regimen of diet and alkalization marked a great advance in ulcer therapy. Due largely to its success and popularity,* the play, for the time being, was again taken from the surgeons. Sippy demonstrated that in many instances, pyloric obstruction, hemorrhage and even some cases of perforation would yield to a well worked out plan of medical management. The sippy treatment dominated ulcer therapy in the second and third decades of the present century and its influence is still felt.

After about 1925 the number of operative procedures applicable to the treatment of ulcer narrowed down practically to gastroenterostomy (Finney's pyloroduodenostomy[16] has been continued in use by some), modified sleeve resections, and subtotal gastrectomy. For several decades gastroenterostomy was routine for elective cases, and in the presence of pyloric stenosis the immediate results were often brilliant.

Finney, in 1902[16] published his pyloroduodenostomy previously referred to, similar to that of Jaboulay whose operation came out in the late 1890's. These operations had for their purpose the relief of stenosis, the opposite of the procedures for the creation of stenosis, in connection with gastroenterostomy as discussed in the preceding paragraph, indicating the confusion in the surgical attempts to remedy the effects of ulcer.

J. B. Murphy[17] of Chicago championed the practice of wide excision of ulcer, and Balfour[18] of the Mayo Clinic wrote praising cautery obliteration of the ulcer in certain cases. These practices, including wedge excisions, were virtually discarded by the end of 1930. Gastroenterostomy, too, though often followed by good results, had begun to lose face because of troublesome complications and the high incidence of postoperative anastomotic ulcer. Under the Sippy regime many ulcer cases hitherto considered surgical were treated conservatively, with at least apparent success. At the height of the Sippy influence, gastroduodenal ulcer became a predominantly medical problem. Inevitably a harvest of late medical unsuccesses turned up at the surgical clinics. Then, by way of reaction, came the booming voice of John B. Deaver[19] preaching that *all* peptic ulcers were surgical. A forceful speaker as well as a master operator, Deaver for a time (the 1920's) had a following in his radical viewpoint. Thus were the two extremes, that of Deaver on the one hand, who contended that ulcer was amenable only "to the aseptic scalpel," and the attitude of a good many medical men on the other, who would treat their ulcer patients unto death before referring them to surgery. Sides were taken and such discussions as "Medical versus Surgical Treatment for Ulcer" and the reverse, were heard in the local medical societies. Middle-of-the-roaders, comprising the bulk of the profession, realized that while some of the cases were inevitably surgical, a large number would make a satisfactory recovery under medical management. There were still grounds for honest differences of opinion about borderline cases.

In the early thirties Meulengracht[20] published the results of a new plan of treatment, contributing the principle of feeding during the active stages of ulcer (including hemorrhage), as opposed to the principle of rest (starvation), so long prevalent. Meulengracht's method attracted world-wide attention and gave another inning to nonsurgical management.

ETIOLOGIC CONSIDERATIONS

By now, (1930-40) clinicopathologic observation and physiologic experiment were combining to formulate a better understanding of the "ulcer phenomenon" (Necheles),[21] as a result of which certain rather generally accepted assumptions could be formulated:

1. **The predominance of excess acid gastric juice as a causative factor.** Dimly recognized by clinicians, perhaps for ages, it remained for Bertram W. Sippy *(loc. cit.)* to prove by an unparalleled series of clinical observations that once the influence of excess gastric secretion is neutralized or removed, peptic ulcerations will heal. Today, all methods of treatment are predicated basically on this concept.

2. **Miscellaneous accessory factors.** (a) Psychic influences on digestive mechanisms, known to observing physicians from time immemorial. Pavlov's classic experiments on conditioned reflexes gave first laboratory confirmation of this influence. Development of the knowledge of hormonal and cephalic phases of digestive activity have served further to clarify the central nervous influences. The psychoneurotic background, and the clinical observation of the evil effects of emotional stress on the ulcer patient are too well known to require elaboration. (b) Chronic fatigue, (c) poor hygiene, (d) tobacco, (e) hypovitaminosis, and (f) alcohol, play roles of varying significance in different individuals. (g) External physical trauma

* A number of gastrologists, notably Frank Smithies, of the Mayo Clinic, later of Chicago, took issue with the Sippy principle, especially in regard to the emphasis on the acid factor.

has been considered as a possible cause by serious authors but the present writer has never seen a case in which physical violence seemed to be an etiologic factor. (h) Extensive skin burns (Curling's ulcer) are known to be associated at times with duodenal ulcer, yet this factor plays an insignificant role in peptic ulcer as seen in everyday practice. (i) Focus in the central nervous system (Cushing's ulcer), foreseen many years ago by Brown-Sequard,[22] brilliant French-African philosopher-physiologist who found that he could produce ulcer in animals by destroying the corpora quadrigemina. This cause of ulcer is of academic rather than practical interest. (j) The fantastic theory of the late George W. Crile, concerning the adrenal influence, and his clinical series of suprarenal denervations on ulcer patients may be remembered. His observations were never taken seriously by other clinical workers. (k) Meyer's (New York)[23, 24] work with lysozyme has not clarified the problem of lowered tissue susceptibility. The belief that ischemia of terminal arteries plays a part in the localization of ulcer has not been substantiated by anatomical studies.

3. **Finally there is an X FACTOR which eludes detection,** wherefore the basic cause of ulcer remains an unsolved problem.

4. Corollary to what has been said, the natural tendency of all ulcers is to heal, failure completely to do so bespeaking the existence of the array of factors unfavorable to this outcome. With present methods it is generally accepted that 80 to 85 percent of all ulcers may heal or be caused to heal without surgery. Whether the percentage of nonsurgical cures can be increased by the use of such new drugs as Banthine remains to be seen. There is a zone of cases susceptible of relief under ideal conservative management, yet in which economic considerations dictate surgery rather than long-drawn-out, imperfectly executed medical measures. There is another, not inconsiderable group of cases which neither surgery nor medicine will remedy unless elimination of the factors of emotional stress and frustration (and cigarette smoking) is possible.

RECENT TRENDS IN ULCER SURGERY

Dragstedt's[25] announcement in 1943 that favorable results in peptic ulcer followed division of the vagus nerves opened a new vista in the surgery of this disease. The procedure had been tried and abandoned by a previous generation of surgeons. With admirable persistence, Dragstedt continued his experimental and clinical observations and became convinced of its efficiency. Yet, despite the optimistic reports of Dragstedt, and of others, it is still a controversial procedure. It has not stood the test of time, although the early results in certain cases are brilliant. Aside from the failures recorded against it, one of the chief handicaps is the almost inevitable bloating, nausea and diarrhea which characterize its postoperative course.

On the other hand, vagus resection has its appeal. In the eyes of many doctors, the patients, and not a few surgeons, this lies in its lesser technical magnitude in comparison with gastric resections; although actually it is by no means a minor procedure. In our opinion its employment is rational in certain clear-cut indications, as later outlined.

OPERATIONS FOR PEPTIC ULCER

At present the following operations are available to the surgeon in the treatment of peptic ulcer: vagotomy, gastrojejunostomy (or gastroduodenostomy) and subtotal gastrectomy. Around these basic procedures surgeons will never cease to improvise oftimes impromptu technics to meet individual circumstances.

We believe vagotomy unsupplemented should be abandoned. A large number of surgeons practice this belief and add gastroenterostomy wherever vagotomy has been performed, thus mitigating some of the untoward effects alluded to above. As stated elsewhere by the author,[26] besides its corrective influence in connection with vagotomy, gastroenterostomy brings an additional therapeutic factor, to which at least part of the credit must be given for benefits that follow the combined procedures. Occasionally total gastrectomy accidentally or on purpose has been done for ulcer, a procedure which of course cannot be recommended. However, one of our cases, reported elsewhere, in which total resection was done under the supposition that cancer existed, has had a favorable outcome after five years.

PHRENICOVAGAL INTERRUPTION

For the purpose of reducing the unpleasant postvagotomy symptoms, the author has suggested the addition of phrenic nerve crush (phrenemphraxis) to vagus nerve section in treating ulcer. Phrenicovagal interruption is a hitherto undiscussed procedure practiced and recommended for employment whenever vagotomy is deemed indicated. A full discussion of the indications for vagotomy in ulcer therapy is not within the scope of this paper, but a statement concerning its applications appears in a later paragraph.

Preliminary reports on phrenicovagal interruption have appeared in previous publications.[27, 28]

The idea of adding the phrenic procedure to vagotomy is based on the observation made by Jefferson and Phillips[29, 30, 31] of our clinic that when this nerve is cut simultaneously with vagotomy in dogs the usual postoperative atony and distention do not occur. Phrenicovagal interruption has been applied in a small number of patients with duodenal ulcer with the view of increasing the efficiency of vagotomy in suitable cases. All of the patients

in whom vagotomy plus phrenic crush has been practiced have had unusually smooth convalescences. The work is undergoing further study in our clinic.

The rationale of our procedure is as follows: the temporary paralysis of the left diaphragm with its resulting ascension into the thorax produced by crushing its motor nerve amplifies the space within the abdomen required for the distended stomach following vagus section. Furthermore, the elevation of the gastric fundus permitted by the high-lying left diaphragm contributes to make the stomach vertical and thus conduces better drainage of this organ. Finally the relaxation of the phrenic musculature around the esophageal hiatus and the relief of cardiospasm further contribute to mitigate the disagreeable effects of gastric dilatation. We believe also that reduction of the vomiting reflex consequent upon phrenic interruption adds to the postoperative comfort of these patients.*

Phrenic nerve crush in the left neck is carried out by an assistant during the main procedure, thus entailing no increase in the total operating time. It is obvious that in transthoracic vagotomies the phrenic nerve may be crushed with hemostatic clamps as it courses along the pleuropericardium.

RESUMÉ OF SURGICAL INDICATIONS

Most duodenal ulcers (85 percent) are medical. Most gastric ulcers are surgical. Many cases regarded as medical cures come late to surgery (perforations, reactivated ulcer, recurrence of bleeding). Most large gastric ulcers with deeply punched-out bases, ulcers that bleed, that penetrate with periduodenal or perigastric pocketing, are potentially or actually surgical even though susceptible of relief by medical means. Likewise, of course, surgical failures come to medicine. However, the vast majority of surgical unsuccesses must come back to surgery and in this modern day can be remedied by the surgeon experienced in this type of work.

Choice of Operation:

1. Vagotomy is indicated in duodenal ulcer if, as usually is the case, free hydrochloric acid is high in the gastric contents. If the element of obstruction is present, gastrojejunostomy should be added. Otherwise, we are coming to believe as a result of increasing experience that simultaneous phrenic crush will largely overcome the handicaps of vagotomy as the main procedure, and that the addition of gastrojejunostomy may often be unnecessary.

2. Vagotomy is indicated in early anastomotic ulcers. It is contraindicated in chronic stomach ulcers, with tendency to perforate. In certain of the latter, vagotomy may supplement high subtotal gastrectomy. Considerable question has lately been raised as to the advisability of this use of vagotomy. In Trimble and Lyons[32] comprehensive review, the adverse opinions of Lahey, Wilkinson and Sullivan and others are discussed. These authors report less favorable results in gastrectomy when vagotomy is added. On *a priori* grounds, the writer is in agreement with these reports. However, the addition of phrenic crush enhances the advantages (reduction of acid) and overcomes largely the disadvantages (postoperative bloating) of vagotomy, hence we have now returned to the use of vagotomy supplemented by phrenic crush as an adjunct to subtotal gastrectomy. This practice we believe will further immunize the incidence of anastomotic ulcer.

3. In the treatment of some cases of ulcer, gastroenterostomy may be the better choice if the risk of gastric resection is deemed excessive. Gastroenterostomy should always be supplemented with vagotomy. As mentioned earlier, the most striking benefits of gastroenterostomy are observed when it is applied for high-grade pyloric stenosis (cicatrizing duodenal ulcer). Performance of gastroenterostomy also serves a useful purpose when, in closing off perforating ulcers, there is doubt as to the patency of the pylorus.*

4. High subtotal gastrectomy remains the overall standard procedure for cases of peptic ulcer that require surgery. It is the operation of choice for gastric ulcer. It is often the best operation for complicated duodenal ulcer, but here it shares indication with vagotomy and gastroenterostomy, as previously mentioned. Five-sixths to seven-eighths of the stomach must be removed. Resective procedures may be contraindicated because of poor risk: age, hypertension, cardiorenal or other serious diseases. Here a gastrojejunostomy, preferably anterior, may be the wise alternative, as already mentioned in discussing the indications for that operation. However, with the safeguards at present available, and a well-practiced technic, it is rare that gastrectomy cannot be done with reasonable safety.

In certain instances, because of periduodenal adhesions, if it seems hazardous to include the pyloric ring in the removed specimen, a cuff of the pyloric wall may be left, from which the remnant of antral mucosa may be reamed out (Bancroft, Rothenberg).[33] This is essentially a modification of the sleeve operation, now largely abandoned.

* A comprehensive study by the author of the phrenic nerve in its historical, physiological and clinical aspects is in preparation. See also La Phrénicectomie, Bérard-Dumarest-Desjacques, Masson et Cie, Paris, 1933.

* In our clinic most cases of acute perforation are now treated by subtotal gastrectomy if seen within eight hours.

OPERATIONS FOR PEPTIC ULCER AND ITS COMPLICATIONS TO JANUARY 1, 1951

Pyloroplasty (Heineke-Mikulicz)		2	cases
Excisions and suture for perforation		12	cases
Gastroenterostomy (all posterior except one)		52	cases
		1	death
Pyloroduodenostomy (Finney)		3	cases
Sleeve resections (Finsterer)		6	cases
Gastrogastrostomy (Hourglass)		2	cases
Partial gastrectomy		101	cases
		5	deaths
Total gastrectomy		1	case
(plus partial pancreatectomy and splenectomy)		1	case
Vagotomy all types		26	cases
(including with phrenemphraxis 7 cases)		1	death
Miscellaneous		7	cases
Jejunojejunostomy for obstruction of afferent loop	2		cases
Jejunostomy for postoperative obstruction	2		cases
Fruitless exploration	1	(death)	case
Anterior gastrojejunostomy for obstruction of efferent loop at stomach	1		case
Exploration for intussusception of jejunum efferent loop Post-gastrectomy	1		case
TOTAL		211	cases

SUMMARY

1. A rapid survey of the panorama of events leading up to the modern era of gastroduodenal surgery is presented.

2. A list of present-day accepted surgical procedures in the treatment of peptic ulcer is given, with a discussion of their indications as employed by me.

3. Reference is made to phrenic nerve crush as an adjunct to vagotomy for the purpose of mitigating the unpleasant effects that so often follow the latter operation. This is a hitherto undescribed technic.

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RETIREMENT

THE best way to retire is to accumulate enough resources to finance complete retirement and then continue regular work at a reduced pace.

The popular notion of retirement to a fishing trip for 365 days per year is popular, all right, but seldom satisfactory. Study of the retirement problem reveals that an active man may suffer acutely from boredom, when he is deprived of the work that has absorbed his energies and supplied the main interest of his life for many years. Unless he has developed outside interests to an unusual degree abrupt cessation of a life's work is often a disappointing and unhappy experience.

What with old people living longer nowadays, with the retirement age about the same, and with more and more persons who are supplied with pensions and the financial ability to retire, the whole problem is a growing one. One indication of this is that there is, at the present time, an increase in the number of problem drinkers in the elderly group—thought to be due to boredom and idleness on the part of the retired worker.

Some corporations are now conducting programs to prepare employees for retirement. Courses are given during the last year of work with the company. Instruction includes lectures on health and living habits of old age. Hobbies are emphasized, but more particularly the question of enabling the worker to adopt some other vocation. It is recognized that the ordinary vacation type of pursuits are not adequate in most cases. Unless the retired person has some gainful work to do, he loses the joy of living.

The old rule as applied to machines and human beings alike is that it takes longer to wear out than it does to rust out. There is no doubt that many a retired person has passed away sooner because he was idle. Even those who live as long, do so with little satisfaction to themselves.

Loafing is no fun unless some worth-while work has been postponed and awaits the loafer when he is rested.

These considerations apply to doctors even more than they do to others. Most physicians are peculiarly self-centered in their profession. Their practices occupy most of their waking hours. As a rule they do not develop outside interests sufficient to carry them through a period of retirement.

For them the plan of accumulating sufficient reserves to make retirement possible, and a continuation of their practice in modified form for as long as they physically are able to do so is an excellent one. With financial reserves at hand it is possible to eliminate the elements of practice which are

especially tiresome. The part of practice which remains is not essential so far as income is concerned, but it is invaluable in maintaining the interest that makes life worth while.

After a life of busy full-time work, a relaxed part-time practice would be especially enjoyable. A consultation practice in a field which has been of special interest but for which time was never available—the little extra time spent with old patients, who are often our best friends—and the opportunity for reading. Medical reading must be dull for a fully retired doctor, but extremely interesting for one who still sees a few patients each day.

MEDICAL INSURANCE

COSTS of long-term chronic illness are more advantageously covered by insurance than are the costs of relatively short acute illnesses.

For purposes of insurance, illnesses may be divided into three classes. The first class is the most common and concerns almost every family at least once a year. It includes short-term and acute sickness, usually not requiring hospital care. It is expensive to carry insurance which will cover this class because the claims are small and the administrative expense is relatively large. It costs about as much to process a small claim as it does a large one. There is no advantage to adding a $10.00 administrative charge to the cost of a $10.00 illness. Since such illnesses are common to all families in a short period of time, the insurance principle of dividing the risk among a large number of people is of no advantage.

The second class of illness is less common but more expensive. It usually requires a surgical operation and/or hospitalization for a few days or a few weeks. Because it occurs only occasionally in any one family and because it involves considerable expense it is ideally covered by insurance. It is the class of illness that is covered by Blue Cross and Blue Shield.

The third class is even less common and much more expensive. It includes the long-term chronic illness which demands at least some hospitalization and for which treatment may extend over many months or even for a few years.

The effects of long-term chronic disease on the finances of a family are catastrophic, even in the case of those who are well-to-do. This field of medical insurance is one which is receiving much study at the present time. It is a type of coverage which will interest everyone, regardless of the extent of their finances.

Insurance which would cover expenses of chronic illness, almost without limit, probably would not be too expensive to carry. The relative infrequency with which it would occur in insurable families would tend to spread the cost over a large number of policyholders. However, the size of the claims which it would incur, and the lack of actuarial data make it difficult to assess the true cost.

Some Blue Shield plans are running pilot programs in catastrophic coverage. This will provide information upon which the programs, if they are successful, may be expanded.

Other insurance companies have been exploring the possibilities of catastrophic medical insurance. Surveys by means of questionnaires have supplied a great deal of basic data.

One company is considering applying the deductible feature to medical insurance. This principle is well known in automobile collision insurance. It serves to eliminate small claims and proportionately high administrative expenses. It makes collision insurance more reasonable in cost, and should do the same for medical policies.

In applying the deductible principle to medical insurance it is thought that each family should have the standard deduction applied to their claims for only one illness each year. During the remainder of the year other illnesses would have a smaller deduction, simply to eliminate small nuisance claims.

Another insurance principle which may be applied to medical claims is the co-insurance factor. This is a provision which requires that the insured person pay a part of the entire bill. This principle is of value since the insured has a financial advantage in keeping the total cost within bounds. It is a principle which will tend to keep the premium cost low.

Voluntary medical insurance is the main defense against socialized medicine. The more nearly it covers the people's needs, the more successful and widespread it will become. It must be written and managed in such a way as to keep the price within the reach of all, or almost all people. Continued study and exploration by both commercial and nonprofit insurance companies will lead to improvement.

RAY E. SMITH MEMORIAL

ON OCTOBER 31, members of the House of Delegates subscribed personally some $8,000 to the Medical Education Fund.

Soon after this action the House unanimously voted to designate the first year's subscription by Indiana physicians to the fund as a memorial to Ray Smith.

Ray was one of the truest friends American and Hoosier medicine ever had. He was interested in all the good things that medicine has accomplished, and cherished the high ideals of the profession as fervently as any of us. He lived a life that was an inspiration and a challenge.

Preservation of the American system of medical education would have been of special interest to Ray. Our subscription fund for the aid of medical education is an appropriate tribute to his memory.

CHARLIE DOES IT AGAIN

OUR Centennial Year was duly celebrated and great were the goings on. One of the most notable (and eventually probably the most enduring) was the book by Drs. Charles N. Combs and Edgar F. Kiser, "One Hundred Years of Indiana Medicine." Now Doctor Charlie has done it again. Since the book is not being published for sale it does not belong under book reviews, but if it *were* being reviewed we should read as follows:

THE HISTORY OF MEDICINE IN VIGO COUNTY, INDIANA, 1818 TO 1951

By Charles N. Combs, M.D. Terre Haute, Indiana, 1951. 575 typewritten pages, with charts and tables, and a foreword by Dr. J. H. Weinstein. It is not for sale, but one copy will be placed in the Indiana State Historical Society Library, at Indianapolis, and another in the Fairbanks Memorial Library, at Terre Haute.

C. N. Combs became early acquainted with Dr. Stephen J. Young who came to Terre Haute in 1851 and between them "we had a combined personal knowledge of all the physicians in Vigo County for the past 100 years." Testimony to this are the 729 biographies of physicians of Vigo County to be found in this book, and in addition there is much historical matter about affairs medical in this county from earliest times—even before 1818.

The table of contents lists twelve chapters which include "History of the Vigo County Medical Society," "History of Other Medical Organizations," "Hospitals," "History of the Auxiliary of the Vigo County Medical Society" (by Mrs. D. B. Miller), war participation by Vigo County doctors, recollections of early doctors, "Cross Sections of Doctors of Various Decades" (by Mrs. Marion Hunter Gray), "Pioneer Doctors" (by Mrs. Miller), "Early Medical Men" (by Mrs. Gray), biographies of 729 doctors, most of them in astonishing detail, and "Miscellaneous Topics." There is evidence on every page of the meticulous and devoted care with which Doctor Combs pursued this task.

As far as we know, only one other Indiana county medical history has been published—that by Dr. James B. Maple, of Sullivan County. It is hoped that others will "go and do likewise" in other counties.

A.W.C.

Editorial Notes

GOLF TOURNAMENT

Eighty-one members participated in the annual golf tournament, during the annual session, played at Meridian Hills Country Club. Low gross honors and the association championship went to Dr. Edwin R. Eaton of Indianapolis, with a solid 73. Dr. K. T. Knode of South Bend was runner-up, with 76, and Dr. P. G. Lindenborg of Indianapolis took third place, with 77. Dr. R. R. Acre, Evansville, was awarded a special prize for "closest to the cup," the distance involved being 12 inches. Bankers handicap was also used in computing prizes. Dr. W. D. Dannacher of Wabash scored a 66 on this basis for first place.

TRAP SHOOT

The 100-target open event was won by Dr. Byron Nixon of Farmland. Second place was claimed by a three-way tie between Dr. John Lansford, Redkey; Dr. F. P. Williams, Huntingburg; and Dr. N. D. Moran, Versailles. A special 50-target novice event was won by Dr. E. E. Rogers of Auburn. Dr. Myron Nourse of Indianapolis placed second.

INSTRUCTIONAL COURSES

The Instructional Courses enjoyed what was probably their best year. The attendance figures exceeded all previous courses and many of the lectures were sold out completely. This popular feature of the Annual Session competes with the recreational part of the program, and has been drawing a better house each year.

Your Patient Is Critical, Doctor!

It will take at least

$1,000,000.00

Yet this year to make him well.

The medical schools of our nation—your own medical school is in dire need of financial assistance. Salaries have increased—supplies cost more—endowment incomes have been reduced, all this adds up to a serious financial problem. Many of our schools are faced with curtailing their programs, some even face closing their doors for lack of funds.

The American Medical Association has issued a call for financial help from the physicians of this nation—we want to keep our schools going under their present system. If our schools are to remain as we know them—your help is needed now.

Members of the House of Delegates of the Indiana State Medical Association gave more than $8,000.00 to start Indiana's campaign to raise $100,000.00 for this worthy cause. We are counting on your help—so mail your pledge or check today.



Clip and Mail Today

PLEDGE CARD

Indiana State Medical Association, Medical Education Fund.

I hereby subscribe ..... DOLLARS per year for a period of (1) (2) (3) years to the American Medical Education Foundation as my contribution to assist our medical schools.

Please bill me

( ) Quarterly
( ) Semi-annually
( ) Annually
( ) Check in full enclosed.

I understand this money will be turned over to the American Medical Education Foundation, with the understanding that my contribution will be given to the following medical school .....

Name ..... M.D.

Address .....

(Make your check payable, Indiana State Medical Education Foundation Fund, 1021 Hume Mansur Building, Indianapolis 4, Indiana)

President's Page

THE one hundred and second annual convention was very successful and the members of the committee who worked so diligently deserve a vote of thanks.

As we approach the Yuletide, the end of another year and the beginning of 1952, we must surely enter into the spirit of the season with a desire in our hearts to disseminate good will and happiness and be ever mindful that it is better to give than receive.

A program of gigantic proportions is presented this year and a little history of the background may not be amiss.

As a result of the decision of the House of Delegates of the American Medical Association at the interim meeting in St. Louis in 1948 to resist any movement of socialization of medicine, a vigorous and well planned campaign was organized, based on a statement of principles.

Time and space will not permit an evaluation of all the results of that venture except to mention the crystallization of and change in public opinion.

One major point stressed by the socializers was the shortage of doctors in some localities even though we have one doctor to about every 730 people. This is greater than any country in the world except Israel, where there exists a very unusual situation.

In an attempt to alleviate this condition the medical schools of the nation were asked to increase their enrollment. This has been done. Our own medical school now has increased its enrollment for the past four years by thirty to thirty-five students.

Medical education costs money and a number of medical schools found themselves in financial difficulty. No doctor or his family has ever fully paid for his medical education. Schools were operated on funds supplied either by taxation or private endowment. With all costs rising above any planned budget it is no wonder that the medical schools were unable to meet their obligations and still maintain the high standard of education. We cannot tolerate any plan that would tend to lower the present standards of medical training.

The National Fund for Medical Education, with Mr. Herbert Hoover as honorary chairman, was not ready to announce its creation about one year ago, so in order to make perfectly clear the attitude and intentions of the American Medical Association, the American Foundation for Medical Education was established.This was necessary in order to have a body which could receive funds from the American Medical Association and others.

The American Medical Association gave a half million dollars to the new Foundation, which it had saved from the National Education Campaign fund. A number of state associations have contributed substantial sums.

The members of our House of Delegates on October 31, 1951, either by check or pledge, subscribed over eight thousand dollars to this fund and now the committee is asking you to demonstrate that Yuletide spirit and give.

We have a duty first as citizens and secondly as doctors to put some of our earnings back into our business in this manner, so that young men and women who succeed us may be trained without the yoke of federal subsidy.

We must not fail.

See Page 1178.

Best wishes for a very Merry Christmas and a Happy and Prosperous New Year!

J. William Wright

Medical Panorama by the Associate Editor

THE BATTLE IS NOT OVER

The Nebraska State Medical Journal is one to which this editor looks forward each month, as it usually contains one or more thoroughly seasoned and well served editorials. A portion of the leading editorial in the September, 1951, issue is worth perusing, and remembering. Complacency is a fault easily acquired, and cast off with difficulty. It may help to recall that some people in Troy were complacent about a certain Trojan horse. Once the horse is within the walls, anything can happen.

* * *

STRAWS IN AN ILL WIND

Three recent events should serve to convince us that in the words of Dr. George F. Lull, Secretary and General Manager of the American Medical Association "Socialized Medicine evidently is far from being a dead fish on the beach."

a. Early in July of this year Senator James E. Murray of Montana, chairman of the Committee on Labor and Public Welfare, addressed a telegram to the governor of each state in an effort to gather information on the distribution of physicians. According to the Senator "it has been proposed" (we need not wonder by whom) "that federal subsidies be used to persuade doctors to move to areas where there is an acute shortage of medical personnel." Each governor was asked to indicate whether in his state there were too many doctors, not enough, or just about enough doctors to meet the needs of its residents.

b. Early in August Mr. William Green, President of the American Federation of Labor issued an appeal to his 8,000,000 members and their families to go all out in their contributions to the Committee for the Nation's Health. He reminded his constituents of their pledge one year ago at their annual convention to continue the fight for national health insurance and for federal aid to train more doctors. The Committee for the Nation's Health, Mr. Green assured them is Labor's best ally, and contributions are needed by this committee to "help defeat the medical lobby's lies at the grass roots."

c. In the August number of this Journal we offered editorial comments on a press release by the Democratic National Committee, which may be considered at least a pre-election feeler on the value of medical socialization as a possible campaign issue in 1952. . . . it would be more than folly on our part to sit back and assume that the public will denounce the false prophets just because we as physicians are against socialized medicine. On the contrary each of us must take it upon himself to familiarize our friends and patients with the true value of professional freedom and what it means in terms of personal medical care to a free people.

PRAISE FROM THE WEST

The following speaks for itself with perfect clarity. It is an excerpt from the presidential address of Harry C. Bryan, M.D., Sept. 21, 1951, before the 81st Annual Session of the Colorado State Medical Society:

While thinking about such matters, may I urge all of you to join me in watching—as I am doing with a great deal of interest—the great test that is now under way between the State of Indiana and the federal government. I refer, of course, to Indiana's demand that it publicize the names of recipients of public welfare funds, and the federal insistence that federal grants for such purposes will be withdrawn. Many legal technicalities are involved which we cannot take time to consider today. But all of us are keenly aware of great and innumerable and almost criminal abuses which the light of publicity could end. I am asking our incoming Public Policy Committee and our legal advisers to consider carefully the possibility of proposing to our own state legislature a bill similar to the recent Indiana law. Several other states are thinking hard about this problem, which is a problem of waste, tragic and horrible waste, of our tax dollars. Think of it, that in today's postwar prosperity our governmental agencies spend more to support the supposedly indigent than was spent in the depth of the great 1933 depression! All congratulations to Indiana people and her state government for asserting her state's rights against federal bureaucracy—may Colorado do the same!

Read the next to last sentence again and try to realize what it means. To those who were adults in 1933 it will mean a great deal; in fact, it will be horrifying. Perhaps we do not always realize how proud the name of Hoosier may deserve to be.

* * *

When we are tempted to prolixity, it might help to remember the following gem culled from *The Rocky Mountain Medical Journal:*

IS THIS PROGRESS?

The story of the creation of the world is told in Genesis in 400 words. The world's greatest moral code, the Ten Commandments, contains only 297 words. Lincoln's Gettysburg Address is but 266 words in length. The Declaration of Independence required only 1,321 words to set up a new concept of freedom. The Office of Price Administration uses 2,500 words to announce a reduction in the price of cabbage seed.

THE DOCTOR AND HIS CRITIC

RAY E. SMITH

(Editor's Note: Shortly before his death, Ray Smith was invited to write an article for GP. It was probably the last writing he did for the medical profession. His article is reprinted with permission of the publisher of GP, with an editorial tribute by the Editor of GP.)

WHILE editing a newspaper some years ago, I received a blistering letter from a subscriber telling me what he thought was wrong with the newspaper. Red-faced with anger, I showed the letter to the publisher, who gave me advice I have always remembered.

"Don't get mad," said the publisher. "Your critic may well be your best friend. Give consideration to what he says. He may be right."

Time and experience have proved the soundness of the publisher's advice. Most often one's critic prescribes a pattern whereby one may improve his works.

Is it possible that critics of medicine are then in reality friends in disguise? Are they unintentionally sounding us a warning to which we should at least listen? Maybe we should give a thought to what they say. Every person and every profession have their faults. Have we the wisdom to rectify the shortcomings that our critics are calling to our attention?

A wise merchant does his best to placate a customer, even knowing the customer is wrong. "The customer is always right," he tells his employees. The merchant may be forced to take a loss on the disputed deal, but he considers the future purchases of the customer and the attendant profit. The settlement is not only good public relations; it is good business. It is money in the merchant's pocket.

Physicians should exercise the same good judgment as the merchant in handling disputes with patients. The patient's complaint may be unfair and unwarranted, but *he* does not think so. Maybe a bit of explaining would help him to understand. When such situations arise, the doctor's diplomacy in handling the matter either wins a friend for medicine or adds another to its list of enemies.

The establishment of grievance committees is a step in the right direction. It is a sad commentary on a proud and noble profession, however, that a disciplinary agency is necessary within its organization. But grievance committees, if they are given the power of censor and use it, show that medicine is trying to sweep its own dirt out of its own house. That is better than having the neighbors—or the government—come in and do it.

The pocketbook seems to be the most tender part of the human anatomy, and most of the critics claim that doctors are too rough with it. This may well be true. Having the privilege of placing a monetary value on his services, it is natural for the doctor to place it high. Where is there a salaried man who doesn't think he earns more than he is paid? The differential between the doctor's view and that of his patient on what is a just fee accounts for most of the ill feeling.

Many times physicians unknowingly gain ill will of patients. Most patients have a deep sense of inferiority in the presence of the superiorly educated doctor, and are timid about saying anything. After leaving the doctor's office, however, they become vociferous in damning that physician in particular and the profession in general, and may even write a letter to the newspaper. As the resentment festers in the mind of the patient, it becomes more inflamed. By inviting views of a patient, and reaching a satisfactory agreement, physicians can prevent this type of criticism.

The average individual comes in contact with but few physicians during his lifetime. When he does, it usually is when frightened and upset. He forms his opinion of the entire medical profession by how he is treated. The importance of satisfactory physician-patient relations, therefore, cannot be overemphasized. The sum total of patient reactions to the hundreds of thousands of daily doctor-patient contacts adds up to what is known as Public Opinion. "Without it," said Abraham Lincoln, "nothing can succeed. With public sentiment, nothing can fail."

No profession or business can long survive without having public approval. If medicine ever needed friends, it needs them now. It's time now for medicine to harken to the voice of the critic. Next year may be too late.

If private medicine should ever go down the socialistic drain, may God have pity upon America!

THIS article by Ray E. Smith, late Executive Secretary of the Indiana State Medical Association, assumes more than ordinary importance for the reason that it was completed only shortly before his sudden and untimely death on August 4. Ray Smith was among the best known and best liked men in America following the career of medical administration. Those who were privileged to know him well have lost a stimulating colleague; Indiana medicine has lost a sincere and conscientious advocate. This article, written at the invitation of the managing publisher, is rather like a final benediction from Ray Smith to the medical men of America whom he so greatly admired.—ED.

PAUL D. CRIMM, M.D.

President-Elect

DR. PAUL D. CRIMM of Evansville was chosen unanimously as president-elect of the Indiana State Medical Association at the 102nd annual convention in Indianapolis on October 31, 1951.



Doctor Crimm is past president of the Vanderburgh County Medical Society. Besides serving his local society in various other capacities he has been delegate to the state association on numerous occasions and has been Chairman of the State Tuberculosis Committee, and alternate Councilor from the First District.

He is a graduate of Ohio Wesleyan University and was granted the M.D. degree from Western Reserve University. He received his hospital training in the University Hospitals, Cleveland. After active service in World War I, he specialized in the surgical treatment of tuberculosis and for the past 22 years has been Director and Thoracic Surgeon for the Boehne Tuberculosis Hospital.

Doctor Crimm has always been active in the civic affairs of Evansville. He is a Rotarian and has served as District Governor in Rotary International. He is Chairman of the Health and Sanitation Committee of the Evansville Chamber of Commerce and is an Assistant Deputy Director in the Vanderburgh County Civil Defense organization.

He is Director and Past President of the Indiana State Tuberculosis Association, and Past Director of the National Tuberculosis Association. He is a member of the American Trudeau Society and American Association for Thoracic Surgery. He is a Fellow of the American College of Chest Physicians and American College of Surgeons.

JAMES A. WAGGENER

Executive Secretary

JAMES A. WAGGENER of Franklin, Field Secretary of the Indiana State Medical Association since May 1949, was chosen as Executive Secretary on October 31, and assumed the duties of his new position at the close of the annual session.



Mr. Waggener was born in Franklin in 1910. He graduated from High School in New Castle, and worked in various assignments on the staff of the *New Castle Courier-Times* for five years.

He now lives in Franklin, with his wife and two daughters. Immediately prior to his work as Field Secretary, Mr. Waggener was Public Relations Director of Indiana Blue Cross-Blue Shield Plans, and for 16 years prior to that he served as Advertising and Business Manager of the *Franklin Evening Star*.

Mr. Waggener has for many years been extremely active in civic affairs. During World War II he was publisher of the Camp Atterbury camp paper, and was director of the Johnson County Civilian Defense Organization which was cited as the best in the 5th Army Area. He was chairman of the committee which raised funds for the building of Johnson County Memorial Hospital and was secretary of its Board of Trustees for four years.

He was also Chairman of the Council on Public Education, Indiana Hospital Association in 1948, and Secretary of the Indiana Nurse Recruitment Committee in the same year.

Mr. Waggener assumes the position of Executive Secretary after having served as Field Secretary in a very able manner. Besides serving as secretary of several of the association's busiest standing committees, he has been diligent in representing Hoosier medicine at numerous meetings and has visited with most of the county and district medical societies. During the past two years he has been in direct charge of the resolutions campaign which has placed Indiana at the head of all other states in the number of resolutions against the socialization of medicine.

INDIANA GENERAL PRACTITIONER OF THE YEAR—1951

DR. A. C. YODER, of Goshen, was chosen as the General Practitioner of the Year for the state of Indiana by the House of Delegates on October 31, 1951. He was nominated for this honor by the Elkhart County Medical Society on a record of public and civic service, which extends almost back to the date of his birth in 1867.



He was reared on a farm in LaGrange County and taught in a country school at the age of 16. He later graduated from Indiana State Normal School and was principal of Vincennes High School for six years. Following this he received the A.B. and M.D. degrees and entered into practice in Goshen in 1902.

Doctor Yoder is widely known in Indiana. He has held every office in his medical society, and is the only doctor to serve as its president twice. He has been president of the Thirteenth District Medical Society, and has been delegate to the state association for 35 years.

A quotation from the speech which nominated him as General Practitioner of the Year will be attested to by all his many friends—"The candidate has always lived up to the high regard with which the lay public holds the family doctor, and has without reservation given himself to its service. Doctor Yoder is a model of modesty and charitable humility."

Indiana doctors congratulate Doctor Yoder and are proud to present his name to the American Medical Association as the General Practitioner of the Year.

REPORT ON TRANSACTIONS OF 102ND ANNUAL SESSION

THE One Hundred and Second Annual Session of the Indiana State Medical Association convened in Indianapolis on October 29, 30 and 31, 1951. A good representation of Indiana physicians was registered for the three-day event. While less than anticipated, final registration showed a total of 2,241 in attendance and was broken down as follows: members, 1,307; guests, 354; auxiliary members, 286, and exhibitors, 294.

The scientific program drew the praise of all attending for its outstanding quality and choice of subjects covered. Papers were presented by eleven out-of-state essayists and the remainder of the subjects were given by our own members.

HOUSE OF DELEGATES APPROVES INTERIM SESSION

The House of Delegates transacted an unprecedented amount of business and decided that effective in 1952 an interim session of the House should be held. The House, in approving another session of the delegates as near as possible six months following the close of this session, expressed the opinion that such action would not only enable the House to transact more business but would give the members more voice in the operation of the association. It is planned to hold the interim sessions in cities throughout the state that could not normally care for the annual session, and this, it was felt, will give more members an opportunity to witness the transaction of association business. The Council is to establish the time and place of the interim session at its January meeting.

ALTERNATE COUNCILORS ABOLISHED

A proposed change in the Constitution was approved, in which the office of Alternate Councilor will be abolished. This action will be published in THE JOURNAL twice during the coming year and final action will be taken at the next annual session, which is to be held in Indianapolis on September 29, 30 and October 1.

Among other actions approved by the House were: Asking the association to sponsor legislation to provide that the **chief of hospital staffs shall become a member of the board of governors of county hospitals.** Established a special committee to study the proposal for using **unlicensed interns from schools approved by the A.M.A. in Indiana hospitals.** The **Grievance Committee** was renamed **Committee on Patient-Physician Relations,** enlarged, and made a standing committee with increased powers.

The House also approved the formation of a **Section on Preventive Medicine and Public Health.** Specific directives were issued to the Board of Directors of Blue Shield to take over from Blue Cross the payment of medical professional services now covered by the Blue Cross Plan, and replaced the present **Committee on Prepaid Hospital and Medical Care** with a **Permanent Study Committee** on this subject. Members of the committee can hold no office in either Blue Cross or Blue Shield. The House also provided a new method to be used in nominating and electing the **Chairman of the Council and Executive Committee.** In the future, both must be done **by secret ballot.**

The **simplified insurance reporting form,** approved by the A.M.A. and the Insurance Underwriting group, which was referred to the House following approval by the Council, was also approved and its use recommended for all insurance reporting.

In an effort to further **medical care for indigent and crippled,** the House approved a resolution calling upon agencies dealing with crippled indigents to establish a uniform means test formulary for their clientele and when adopted, that it be placed in operation on a state-wide basis. Also, a resolution calling upon the Indiana Hospital Association to establish hospital admittance procedures for crippled indigent, which will indicate if the patient has hospital, surgical or medical insurance, and if so, that these persons be considered non-indigent unless financial distress can be definitely established.

Resolutions were adopted in which the Indiana Delegates to the A.M.A. were called to present and work for passage of a resolution expressing the **objection of the A.M.A. to the placement of chiropractors in the same classification as physicians for deferral purposes under the selective service system.** Another called for the A.M.A. to assume full responsibility for the **standardization of professional practices in hospitals,** and that its committee for this purpose include specialists, general practitioners and medical educators. A resolution for presentation to the A.M.A. memorializing the memory and services rendered the medical profession by the late **John Hayes,** former Indiana resident and for years a legislative representative of organized medicine in Washington.

Resolutions calling for the **redistricting of the Councilor districts** to conform with Congressional districts were again disapproved. Also disapproved was a resolution calling for lowering the age of eligibility for **senior membership from 75 to 70 years of age.** A resolution calling for allowing each section one voting delegate was also disapproved.

In other action by the House it was requested that **Councilors meet with the officers and delegates from the counties within their districts** prior to each Councilor meeting in order to discuss forthcoming business of the Council with the members of their districts.

The committees were all highly commended for the work evidenced by their reports.

Officers elected were:

President-elect—Paul D. Crimm, M.D., Evansville.

Treasurer—Roy V. Myers, M.D., Indianapolis.

Assistant Treasurer—John M. Whitehead, M.D., Indianapolis.

Delegates to the A.M.A.—F. S. Crockett, M.D., LaFayette, and Wendell C. Stover, M.D., Boonville; Alternates—Robert H. Rang, M.D., Washington, and Cleon A. Nafe, M.D., Indianapolis.

A. S. Giordano, M.D., South Bend, whose term expires as A.M.A. delegate December 31, 1952, resigned in favor of Alfred Ellison, M.D., South Bend. The resignation is to take effect December 31, 1951.

French Lick was selected as the site **for the 1953 sessions.** The **1952** sessions will again be held in **Indianapolis.**

The Council re-elected Frank B. Ramsey, M.D., Indianapolis, Editor of THE JOURNAL and A. W. Cavins, M.D., Terre Haute, as Associate Editor of THE JOURNAL. Editorial Board members elected for a three-year term were: Richard H. Miller, M.D., Ft. Wayne, and George M. Cook, M.D., Hammond.

Election of section officers resulted in the following:

Section On Surgery: Chairman, Norman F. Richard, Shelbyville; Vice-chairman, Karl M. Koons, Indianapolis; Secretary, Thomas C. Haller, Crawfordsville.

Section On Medicine: Chairman, William D. Province, Franklin; Vice-chairman, Richard M. Nay, Indianapolis; Secretary, Paul L. Stier, Ft. Wayne.

Section On Ophthalmology and Otolaryngology: (No meeting held, so officers of previous year remain as follows:) Chairman, Robert A. Smith, New Castle; Vice-chairman, Thomas W. Johnson, Indianapolis; Secretary, Edwin W. Dyar, Indianapolis.

Section On Anesthesiology: Chairman, Edson C. Fish, South Bend; Vice-chairman, Arthur W. Hull, Elkhart; Secretary, V. K. Stoelting, Indianapolis.

Section On General Practice: Clarence C. Herzer, Evansville; Vice-chairman, Bernard Edwards, South Bend; Secretary, Norman R. Booher, Indianapolis.

Section on Obstetrics and Gynecology: Chairman, C. O. McCormick, Sr., Indianapolis; Vice-chairman, Ira Cole, Lafayette; Secretary, Floyd T. Romberger, Jr., Indianapolis.











1. Dr. J. Wm. Wright, incoming president, presenting certificate of merit to Dr. Alfred Ellison, retiring president.
2. Dr. Ellison presenting the gavel to Dr. Wright, as Dr. Louis H. Baner, Hempstead, N.Y., president-elect of the AMA, applauds.
3. E. E. Ewbank, DDS, secy., Indiana State Dental Society; Wray E. Fleming, gen. counsel and mgr., Hoosier State Press Assn.; Robert H. Wyatt, exec. secy., Indiana State Teachers Assn.; W. P. McNulty, DDS, pres., Indiana State Dental Society.
4. Emery A. Badanish, Gary, pres., Indiana Pharmaceutical Assn.; Dr. Alan C. Woods, Baltimore, speaker; Thomas A. Hendricks, secretary, Council on Medical Service, AMA; Dr. W. L. Portteus, Franklin, chairman, Exec. Com.; Dr. Earl W. Mericle, pres., Indianapolis Medical Society; Dr. W. U. Kennedy, New Castle, chairman of the Council; Roy V. Myers, Indianapolis, treasurer ISMA.
5. Top row: Dr. R. L. Sensenich, South Bend, former president of AMA and ISMA; Dr. A. C. Yoder, Goshen, General Practitioner of the Year; Sen. Karl E. Mundt, Madison, South Dakota, speaker; Dr. Ellison, Dr. Baner; Dr. Wright; Dr. C. E. Gillespie, Seymour, representing 50 Year Club members; Dr. Paul D. Crium, Evansville, president-elect; Dr. E. B. Howard, asst. secy. AMA.

   Bottom row: Dr. N. J. Garber, Indianapolis, chairman convention arrangements; Dr. John D. Van Nuys, dean I.U. School of Medicine; Mrs. F. M. Fargher, Michigan City, pres., Woman's Auxiliary; Miss E. Nancy Scramlin, R.N., exec. secy., and Mrs. Helen R. Johnson, R.N., pres., Indiana State Nurses Assn.; Col. H. C. Doane, commanding officer, Camp Atterbury Hospital; Dr. F. B. Ramsey, editor THE JOURNAL; Dr. E. G. Waters, Jersey City, N.J., speaker; Dr. W. D. Robinson, Ann Arbor, Mich., speaker.

News Notes

MEDICAL STUDENTS TO PUBLISH MAGAZINE

The first issue of the *Journal of the Student American Medical Association,* a 72-page publication, will make its appearance in January, Russell F. Staudacher, executive editor, has announced.

Published nine months of the year—skipping July, August and September when schools are closed—the magazine will have a circulation of more than 33,000. It will be sent to 26,191 medical students and approximately 7,000 interns.

The Journal's contents will be approximately one-half editorial and one-half advertising. About 80 percent of the editorial space will be equally divided between scientific articles and socio-economic articles.

EXAMINATION FOR MEDICAL OFFICERS

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held on February 5, 6, and 7, 1952. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received *no later than January 2, 1952.*

Application forms and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C., attention: Division of Commissioned Officers.

NEW VA HOSPITAL APPOINTMENTS

The Veterans Administration announced several promotions and transfers involving the positions of assistant managers in VA hospitals at Fort Wayne and Indianapolis.

A vacancy in the position of assistant manager at the Fort Benjamin Harrison VA Hospital at Indianapolis had been created recently with the transfer of the former assistant manager to the Little Rock, Arkansas, hospital.

To fill the Indianapolis vacancy, VA named Dallas G. Warne, assistant manager of the Fort Wayne VA hospital. Edward J. Geran, personnel officer at the VA Hospital in Cleveland, Ohio, then was appointed to the position of assistant manager at Fort Wayne.

Mr. Warne, 56, has been with VA and its predecessor agencies since 1922 when he was employed as a storekeeper. He became assistant manager of the new Fort Wayne Hospital last March. He is a native of Hobbs, Indiana.

Mr. Geran, 41, is a native of Holyoke, Massachusetts. He was employed by VA as a personnel officer in the Cleveland Hospital in May, 1946, after four years in the Army, where he reached the rank of captain. He obtained his Bachelor of Science Degree at the University of Pennsylvania in 1931.

UROLOGY AWARD

The American Urological Association offers an annual award of $1,000.00 (first prize of $500.00, second prize $300.00 and third prize $200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before February 15, 1952.

ESSAY AWARD

The American Society for the Study of Sterility announces the opening of the 1952 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of one thousand dollars, and the essay will appear on the program of the 1952 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1952. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Massachusetts.

Dr. Kenneth L. Craft, of Indianapolis, was elected president-elect of the American Society of Otolaryngologic Allergy at its annual meeting in Chicago in October.

Dr. Milo K. Miller, of South Bend, has been appointed chief of staff of the Northern Indiana Children's Hospital for a two-year term by Governor Henry F. Schricker.

Dr. John A. Crawford, who recently completed another tour of duty in the Army, is now associated in the practice of orthopedics with **Drs. Harvey W. Sigmond** and **Henry S. Tanner** at 301 Hume Mansur Building, in Indianapolis.

Dr. Joseph H. Nodurft, who recently completed a residency at the Indiana University Medical Center, has assumed directorship of the department of anesthesiology at Wheeling Hospital in Wheeling, West Virginia.

Upon completion of a residency in obstetrics and gynecology at Indianapolis General Hospital, Dr. **John H. Perry, Jr.**, is now in practice in Wichita Falls, Texas.

Dr. **Charles E. Moon** has opened an office for the general practice of medicine in Center Point. He is a graduate of the Loyola University, in Chicago, and spent three years with the U. S. Army Medical Corps. For the past six years he has been in practice in Peoria, Illinois.

A native of New Castle, Dr. **William Saint** has returned there, to become associated in the practice of surgery with Dr. **James S. McElroy**. Doctor Saint is a graduate of Indiana University School of Medicine, and spent his internship at Indianapolis General Hospital. Following this he entered the U. S. Army Medical Corps. After his release from service, he spent two years as resident surgeon at Indianapolis General Hospital.

Dr. **George V. Teter** has opened an office for the practice of pediatrics at 401 East 34th Street in Indianapolis. A 1946 graduate of the Indiana University School of Medicine, he served his internship at Indianapolis General Hospital, and completed two years of postgraduate work at Children's Medical Center in Boston.

Dr. **Edward F. Wierzales** recently opened an office for the general practice of medicine in Hartford City, following his release from the Army on September 1. He is a 1946 graduate of Temple University School of Medicine, in Philadelphia, and interned at King's County Hospital in Brooklyn, New York.

Dr. **Charles Yale**, a native of Fairmount, has begun the practice of medicine in Winamac. He spent his internship at Indianapolis General Hospital, after graduating from Indiana University School of Medicine in 1949.

Dr. **Gerald E. Kasting**, a 1949 graduate of Indiana University School of Medicine, is now associated with the Lamkin-Maly Clinic in Sardinia, Ohio.

A 1944 graduate of Indiana University School of Medicine, Dr. **John E. Krueger** is now in private practice of anesthesiology with Drs. **Edson Fish** and **John Karn** in South Bend. Doctor Krueger recently completed postgraduate work at the Indiana University Medical Center.

Dr. **Howard E. Rothring**, who recently completed postgraduate work at Indianapolis General Hospital, is now located in Columbus.

A.M.A. WASHINGTON OFFICE NEWS

Senate Committee Favors Deduction Of Medical Expenses And Health And Accident Insurance Premiums From Taxable Income. The Senate Finance Committee September 6th voted a provision to the revenue bill permitting the deduction from taxable income medical expenses including health and accident insurance premiums for taxpayers 65 years of age and over and their spouse. Present law permits deduction of medical expenses from taxable income for taxpayers and their dependents exceeding 5% of adjusted gross income. However, the maximum deduction is limited to $1,250 for the taxpayer or $2,500 for the taxpayer and all his dependents. The A.M.A. has for several years favored similar legislation to stimulate greater sales of voluntary insurance. In the last Congress there were approximately fifteen bills introduced to exempt medical expenses, including health and accident insurance premiums, from taxable income, one of which was S.1969 introduced by Senator Ralph E. Flanders (R.-Vt.). Senator Flanders, incidentally, is a member of the Senate Finance Committee. The actions of the Senate Finance Committee have been executive in character and because the bill has not been officially favorably reported by the committee, none of the committee members wished to be quoted.

One of the national legislative dailies commented that the Finance Committee's action is in contrast to the Ewing plan "of free hospitalization for persons over 65 years of age eligible for social security benefits." The Committee expects to report the entire revenue bill to the Senate floor by September 17th and during that week Senate leadership expects the bill to be passed. If this provision is not eliminated by the Senate there is strong reason to believe it will become law.

Senate Boosts CDA Medical Funds. The *Senate* has added $32 million to the *House* figure for medical supplies under the Federal Civil Defense program, for a total of $60 million. This insures that *the final bill will carry a figure somewhere between $28 and $60 million.* Defending the Senate figure as adequate, Senator Styles Bridges (R.-N. H.) said: "If we provide a greater figure, we shall be competing with medical supplies for private individuals and we shall force prices up. I do not believe that the program can consume or utilize more than a $60 million item for medical supplies." Senator Blair Moody (D.-Mich.), argued for a higher figure. Instead, it was suggested that CDA make a more detailed presentation of needs in connection with another appropriation bill still to be considered.

Prescription Bill Passes House, Awaits Truman Signature, Congress Adjourns.

Unless President Truman vetoes the bill—and there's no indication he will—*a new prescription law will be in effect shortly.* Without debate, the House approved Senate changes in H.R. 3298. The bill legalizes telephone prescriptions, gives statutory definition for prescription-only drugs, requires use of prescription legend on prescription drugs but prohibits its use on over-the-counter drugs and gives Food and Drug Administration new authority to act against "firms engaged in a business of dispensing drugs pursuant to diagnosis by mail."

Originally both Senate and House bills carried authorization for the Federal Security Administrator to classify drugs as prescription-only or over-the-counter. This was eliminated on House floor and in Senate Committee. A new bill (H.R. 5718, by Rep. Kenneth Roberts, D., Ala.) would take this authority out of the hands of the pharmaceutical industry and the medical profession, where it now resides, and set up a special independent National Drug Commission to classify drugs. It would be made up of the Food and Drug Commissioner, and 10 presidential appointees, three to represent the druggists, three the general public, three the manufacturers and one the medical profession. Coming so late in the session, the Roberts bill had almost no chance of consideration before reconvening of Congress in January.

Sickness Survey Delayed; Original S. 337 Back on Calendar. Senate Labor and Public Welfare Committee has decided to put off action on a *sickness survey* until start of the next session in January. The original proposition was for a nationwide survey of sickness and disability, at a cost of $700,000. Surgeon General Scheele, however, suggested that a study first be made of methods for conducting the survey. Indications are the Committee may follow his advice, but at the same time recommend the complete survey to be conducted at a later date . . . S. 337, for *federal aid to medical, dental and nursing education,* is back on the Senate calendar, where it may be considered next session. The Labor and Public Welfare Committee reported it out, after Senator Humphrey had cleared the way by withdrawing his motion for reconsideration of the vote by which the bill was recommitted to Committee on October 4. In reporting out S. 337 for a second time, the Committee dropped the proposed *Pastore amendment,* an adverse vote on which preceded recommittal of the bill. The Pastore plan would greatly increase incentive payments for students in excess of normal enrollment. Note: the bill now is the *original* S. 337, as first reported out by the Committee. . . . The proposal for federal aid to nursing education —which is a part of S. 337—may come before the Senate next session as a separate bill. One member of the Labor and Public Welfare Committee is considering introducing a bill embodying provisions of H. R. 910, Rep. Frances Bolton's bill for aid to nursing schools.

Indiana University News Notes

Dr. Gerhard Domagk, noted German pathologist, and Nobel Prize winner for the introduction of the sulfa drugs, and Lt. Col. Arnold M. Meirowsky, whose neurosurgical work in Japan and Korea has received wide acclaim, were visitors to the Medical Center campus the week of September 16. During Dr. Domagk's visit he spoke to members of the staff and interested persons in the Medical School auditorium on the subject "Chemotherapy of Tuberculosis with the Thiosemicarbazones."

Col. Meirowsky visited with his parents, Dr. Emil Meirowsky, of the Surgery Department, and Mrs. Meirowsky.

Edmund J. Shea, assistant administrator of the Medical Center, became a Fellow in the American College of Hospital Administrators during a special convocation of the College held in St. Louis recently. The honor was awarded in recognition of his outstanding record in hospital administration, his activity in the field of hospital management and his thesis on, "A Pilot Installation for Morbidity Reporting."

Dr. W. Foster Montgomery, member of the Medical Center staff, was chairman of the American College of Surgeons delegation to the Eighth Inter-American Congress of Surgery held October 1-6 in Buenos Aires. Dr. Montgomery also appeared on the program as a co-relator on the theme, "Recurrent and Marginal Peptic Ulcer-Postoperative Treatment." Dr. Montgomery was a delegate to the meeting last year, held in Lima, Peru, and presented a paper in Spanish.

Dr. J. K. Berman of the Department of Surgery has returned from a trip through the western states during which he presented lectures before medical groups in Cheyenne, Wyoming; Denver, Colorado, and Albuquerque, New Mexico.

A Psychosomatic Forum will be held on the first Monday of each month in the Auditorium of the Clinical Building of the Medical Center at 8 p.m. and is open to all interested persons.

Nine members have been added to the teaching staff of the Indiana University School of Medicine.

Dr. Orville T. Bailey, former staff member of Harvard University Medical School, has been named professor of neuropathology. He is a diplomate of the American Board of Pathology.

Dr. Francis E. Stout, an Indiana University School of Medicine graduate, became an instructor in the department of gynecology and obstetrics.

Dr. John R. Russell was named an instructor in neurosurgery. He recently completed residencies in hospitals in Chicago and Memphis. He is a graduate of the University of Chicago Medical School.

Dr. John R. Scott, an Indiana University School of Medicine graduate, will serve as an instructor in pediatrics.

Dr. Charles E. Test has been named part-time instructor in medicine. He is a graduate of Princeton University and University of Chicago Medical School, where he served as an instructor in medicine.

Named as an instructor in anesthesiology, Dr. Franklin B. McKechnie is a graduate of Harvard University and Johns Hopkins Medical School.

Dr. Malcolm A. Holliday, a graduate of the University of Virginia and research fellow in pediatrics at Harvard and Yale medical schools, will serve as instructor in pediatrics.

A former chief resident in surgery at the Medical Center, Dr. Thomas C. Moore became an instructor in surgery. He is a graduate of Dartmouth College and Harvard Medical school.

Dr. Dale M. Schulz, former assistant in pathology at Washington University School of Medicine, St. Louis, has been named a teaching fellow in pathology.

Dr. Stanley P. Reimann of Hahnemann Medical College was a visitor on the campus recently as guest speaker for the cancer postgraduate course. He was impressed by the changes which had occurred on the campus since his previous visit several years ago, especially the facilities now available in the Riley research wing.

An additional honor came to the campus when members of the American Association of Medical Record Librarians named Miss Gertrude Gunn as second vice-president of the organization. The election took place during a recent convention in St. Louis.

First of the second annual series of Telephone Seminars, presented jointly by the I. U. School of Medicine and the Indiana State Medical Association, was held Tuesday, October 2, in the Medical School Auditorium with members of the Indianapolis Medical Society in attendance.

Dr. J. O. Ritchey, Professor and Chairman of the Department of Medicine, served as moderator with Dr. J. A. Campbell, Department of Radiology; Dr. Glenn Irwin and Dr. Helen VanVactor, Department of Medicine; Dr. Frank B. Ramsey, Department of Surgery; and Dr. Harry Ross of Richmond, members of the panel. The panel discussion was on the "Treatment of Hyperthyroidism."

A grant of $1,000 has been received by Dr. L. W. Freeman from the Midwest Veterans' Chapter of the National Paraplegia Association, for continuation of some phase of his work in the field of paraplegia.

Approximately 200 people were on the campus October 9 attending the Rehabilitation Day program. The program was presented through the cooperation of the State Department of Public Welfare, Division of Vocational Rehabilitation, Vocational Rehabilitation for the Blind, and the Health and Welfare Council.

Speakers of the day were Dr. Eugene F. Murphy, Assistant Director of Research, Department of Medicine and Surgery, Veterans Administration, Washington, D. C., and Dr. Sedgwick Mead, Assistant Professor of Physical Medicine, Washington University School of Medicine, and Chief of Physical Medicine at Barnes Hospital, St. Louis.

Dr. Harris B. Shumacker, Jr., Chairman of the Department of Surgery, was in Washington recently attending a meeting of the Surgery Committee of the National Research Council.

Indiana State Medical Education Fund

See Page 1178

Deaths

John W. Strange, M.D., of Loogootee, who was selected as the Indiana General Practitioner of the Year in 1950, died suddenly on October 15, while calling on a patient. He was seventy-five years of age. He had practiced in Martin County ever since his graduation from the Medical College of Indiana, in Indianapolis, in 1903. He was a member of the Daviess-Martin County Medical Society and the Indiana State Medical Association, and was a fellow of the American Medical Association. During the annual convention of the Indiana State Medical Association, a resolution was presented commending Doctor Strange, a copy of which appears in the minutes of the House of Delegates on page 1222.

John R. Ranes, M.D., of Mt. Vernon, died on October 25, after a long illness. He was seventy years of age, and had practiced in Mt. Vernon for forty years. He graduated from Indiana University School of Medicine in 1908. He was a member of the Posey County Medical Society, the Indiana State Medical Association, and the American Medical Association.

L. Doyte Holliday, M.D., of Fairmount, died on November 1, after a brief illness, at the age of sixty-seven. After graduating from the Medical College of Indiana, in Indianapolis, in 1905, he entered the practice of medicine with his father in Fairmount. He had practiced in Fairmount for forty-six years. Doctor Holliday was a member of the Grant County Medical Society, the Indiana State Medical Association, and the American Medical Association.

James W. Aldridge, M.D., of Covington, died on October 31, in Danville, Illinois. He was sixty years of age. He was a graduate of the University of Illinois College of Medicine, in Chicago, in 1913. He was a veteran of World War I, and had practiced in Covington since his release from service in 1917. Doctor Aldridge was a member of the Fountain-Warren County Medical Society, the Indiana State Medical Association, and the American Medical Association.

William C. Butman, M.D., of Hebron, died suddenly on September 30, at the age of seventy-one. A graduate of the Southwestern Homeopathic Medical College and Hospital, in Louisville, in 1905, he had practiced in Hebron for more than thirty years. He was a member of the Porter County Medical Society, the Indiana State Medical Association, and the American Medical Association.

William G. Crawford, retired physician of Terre Haute, died on November 6 in Chicago. He was a 1908 graduate of Indiana University School of Medicine, and had practiced in Terre Haute for many years before his retirement. Doctor Crawford was a member of the Vigo County Medical Society and the Indiana State Medical Association, and was a fellow of the American Medical Association.

Charles A. DeLong, M.D., of Gary died on October 23, after a long illness. He was seventy-seven years of age. He had retired from active practice last July, after having practiced in Gary for more than forty-four years. Doctor DeLong was a 1905 graduate of Rush Medical College, in Chicago. He was an Honorary member of the Lake County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Your Medical School Needs Your Support

See Page 1178

pp. 1171–1178 are index pages

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

MEDICAL PROFESSION USES ADVERTISING IN 'AMERICAN WAY'

The medical profession's support of the American way of life is set forth in an advertisement by the Indiana State Medical Association on page two of this week's issue of The News. The advertisement points out that local physicians are available and that each individual should have his own physician and meet him as a friend.

Advertising by the Medical Association discloses that the group no longer regards such advertisements as unethical, and finds it practicable to speak by that means, as published in newspapers, directly to the public in order to bring about better understanding and cooperation between the profession and the general public. Some associations of other professional men still use the threadbare talk that advertising in newspapers is unethical and beneath their dignity.

The current Medical Association advertisement urges that an individual can plan the cost of service with his doctor in advance. It adds that sometimes hospital and medical care seem expensive, "but Indiana's voluntary health insurance plans provide for unusual expenses adequately, and efficiently." If you need a doctor in an emergency and can't locate your doctor, just call the local telephone operator.

While the advertisement does not mention directly the Socialist compulsory medical care in some foreign countries, it states that "Our type of medical care proves to be much faster, much more flexible and much more efficient than that in other countries which control the practice of medicine."

—*Veedersburg News.*

SELLING SOCIALISM

In a recent Saturday Evening Post article, which has been widely quoted and reprinted, Charles Stevenson described government activities in the field of propaganda—paid for, of course, by all the taxpayers.

One section of his article dealt with the Federal Security Agency's labors on behalf of compulsory government health insurance and related legislation. According to Mr. Stevenson, anyone who challenges the program "stands denounced in the FSA's speech news releases as a 'reactionary' who is against health, against social security, against education, against a living wage, against everything that means anything to ordinary people, and in the end against our very liberty, our opportunity, our hopes for the future."

Mr. Stevenson also pointed out that the American Medical Association was roundly abused for spending money to fight compulsory health insurance, which it believes would dangerously undermine our standards of medical care and make the doctor the servant of the politician. Yet, he said, FSA has apparently been spending far greater tax-supplied sums for its own propaganda. He cited a case where a man appeared before a congressional committee to argue for health insurance as an independent citizen. He got in 9,000 words of testimony before questioning disclosed he was a full-time employee. He was then in the Labor Department, and later was employed by FSA.

Mr. Stevenson described many such instances. Every possible form of pressure was used to sell a health insurance scheme which, if historical precedent means anything, would have been merely a prelude to socialized medicine. Mr. Stevenson said, "These campaigns are typical of propaganda techniques that are spreading throughout the government."

Luckily, the people weren't fooled—the health insurance scheme has been shelved. But that's only a temporary stratagem. It will be back—and the only way we can be sure of stopping it is to be eternally vigilant.

—Butler (Ind.) *Rec.-Herald*

Ray E. Smith Memorial Fund

See Page 1178

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

(Indianapolis Session, 1951)

First Meeting

The first meeting of the Council was held in the East Room of the Athenaeum, Indianapolis, at 11:00 a.m., Monday, October 29, 1951, with Dr. W. U. Kennedy, the chairman, presiding. Roll call showed the following present:

Councilors:

First District ——— Herman T. Combs, Evansville
Paul D. Crimm, Evansville, alternate
Second District ——— William C. Reed, Bloomington
Third District ——— William H. Garner, New Albany
Fourth District ——— George S. Row, Osgood, alternate
Fifth District ——— A. M. Mitchell, Terre Haute
M. C. Topping, Terre Haute, councilor-elect
V. Earle Wiseman, Greencastle, alternate
Sixth District ——— W. U. Kennedy, New Castle
Seventh District ——— Roy A. Geider, Indianapolis
Don E. Wood, Indianapolis, alternate, and co-chairman, Legislative Committee
Eighth District ——— E. H. Clauser, Muncie
F. E. Keeling, Portland, councilor-elect
T. R. Hayes, Muncie, alternate
Ninth District ——— Wemple Dodds, Crawfordsville
Harry E. Klepinger, Lafayette, alternate
Tenth District ——— William H. Howard, Hammond
J. Robert Doty, Gary, alternate
Eleventh District ——— Elton R. Clarke, Kokomo
Twelfth District ——— M. B. Catlett, Fort Wayne
Thirteenth District ——— Kenneth L. Olson, South Bend
G. O. Larson, LaPorte, alternate

Officers:

Alfred Ellison, South Bend, president
J. William Wright, Indianapolis, president-elect
Roy V. Myers, Indianapolis, treasurer
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL
A. W. Cavins, Terre Haute, associate editor of THE JOURNAL

Members of Executive Committee:

W. L. Portteus, Franklin, chairman
C. J. Clark, Indianapolis
Thomas A. Hendricks, Chicago, executive secretary emeritus
Albert Stump, Indianapolis, attorney

Delegates and Alternates to the A.M.A.:

F. S. Crockett, Lafayette, delegate
A. S. Giordano, South Bend, delegate
Cleon A. Nafe, Indianapolis, alternate, and chairman, Indiana A.M.A. Campaign Coordinating Committee
Karl R. Ruddell, Indianapolis, alternate
E. S. Jones, Hammond, alternate

Committee on Convention Arrangements:

J. Neill Garber, Indianapolis, chairman

Committee on Public Policy and Legislation:

Norman R. Booher, Indianapolis, co-chairman
Miss Lucille Kribs, assistant secretary
James A. Waggener, field secretary

On motion of Drs. Mitchell and Geider, the minutes of the July 15, 1951, meeting of the Council, held in Indianapolis, were approved as printed in the September, 1951, JOURNAL.

District meetings were reported scheduled as follows:

Fifth District	May 14, 1952, Greencastle
Ninth District	May 21, 1952, Crawfordsville
Eleventh District	May 21, 1952, Kokomo
Thirteenth District	November 14, 1951, South Bend

Dr. E. H. Clauser, retiring councilor of the Eighth District, presented the following report:

In December, 1940, I was honored by the presidents of the counties making up the Eighth District Medical Society by being named its temporary councilor. The office was vacant as a result of Dr. M. A. Austin's promotion to the office of president-elect of the Indiana State Medical Association. With much generosity, patience, and tolerance, I have been permitted to serve continuously in this office, with my present term ending in December of this year.

During these 12 years I have learned much about the problems of organized medicine, the chief of which is the realization of the importance of organized medicine in the welfare of our country. I shall be forever grateful for my having had this opportunity.

In bringing to a close this, my last year as a member of the state Council, I should like to comment briefly on one or two impressions I have developed regarding the part played by the Council in performing its duties and offer a suggestion which I believe would improve the effectiveness of its work. Referring to the constitution and by-laws of the Indiana State Medical Association, I note that the Council is referred to more than fifty times in pointing out its duties and responsibilities. It does not determine policies, nor does it legislate; but in almost all other actions which affect the welfare of the association, it plays a very important role.

As each year passes, more work seems to be added to the Council's load. Each of its sessions contains a greater number of items listed on the agenda, and the sessions are becoming more numerous. Only a decade ago three sessions annually seemed to be adequate for disposing of all matters which were referred to the Council for action. Now, five regular sessions are required.

I seem to observe, too, that the members of the Council realize the need for greater strength in public relations—are more and more impressed with the necessity of holding to moral and ethical standards. They feel that only by being internally sound can we successfully weather the storm of criticism in the long run.

I have suggested that the Eighth District change its by-laws to restrict its councilor to a period of not more than two terms. Service on this Council provides opportunity for schooling the physician regarding the machinery of the State Association. Limiting the period of service would not only give the Council the benefit of a broader viewpoint of the entire membership but would also give opportunity for a greater number of members to learn of the problems confronting the profession.

During the last 30 years the Eighth District has afforded but two persons the opportunity and responsibility of serving on the state Council. A limitation of the period of service would have provided the district with a larger number of persons, who, because of their experience on the Council, would have continued to manifest an intense interest in the problems of organized medicine; and to this extent the entire membership would have been strengthened.

Our neighboring state of Ohio provides in the by-laws of the State Association that no councilman shall serve longer than a period of six years.

Our State Association by-laws call for the selection of councilmen by approximately one-third of the districts each year. A limitation of the term of service in the district would be in agreement with the principles stated by the State Association.

It has been a pleasure, it has been an honor, it has been a very great privilege for me to have served on the Council during the last 12 years. I thank each member of this body for the congenial, cooperative, and tolerant attitude shown me during my efforts with you.

The knowledge and insight gained by experiences in the state Council gives me profound personal satisfaction, for which I shall be forever grateful. Of still greater reward is that friendship which develops among every group of persons with like purpose and like objectives who are serving a great cause, especially the profession of medicine. (Applause.)

Dr. A. M. Mitchell, retiring councilor of the Fifth District: "This is my last meeting with the Council. I have served here for about fourteen years and it has given me much pleasure. If in the future my health permits, I will do anything that I can or am asked to do by the Council. Thank you." (Applause.)

Unfinished Business

1. *Convention arrangements.* Dr. J. Neill Garber, chairman, spoke briefly on the entertainment that had been planned for the 1951 annual convention, and presented the following points for consideration of the Council:

   a. Advisability of inviting A.M.A. president-elect each year as banquet speaker.
   b. Number of speakers on banquet program.
   c. Method of financing convention.

2. *Resolution to provide for eouneilor meetings with eounty society officers and delegates.* Dr. Geider moved that the Council rescind its approval of the resolution, drafted by the attorney for the association as a result of the suggestions made by Dr. Ellison at the July 15, 1951, meeting of the Council and approved by the Council at that time. Motion seconded by Dr. Mitchell. This resolution would amend Section 1, Chapter VII of the By-laws. Following discussion by Drs. Howard, Clarke, Ellison, Olson, Mitchell and Catlett, the motion to rescind approval was lost on a standing vote.

On motion of Drs. Combs and Clauser, the Council voted to place these proposed meetings on a voluntary basis for one year and if this is not satisfactory, to refer the matter to the House of Delegates for action. (See page 1210, House of Delegates' minutes, for copy of resolution.)

3. *Reeommendations of Council for strengthening Sub-Committee on Physician-Patient Relations.* The attorney for the association read the resolution. (See page 1213, House of Delegates' minutes.)

Dr. Wright said he felt that the name suggested in the resolution—"Board of Appeals on Patient-Physician Relations"—which is a substitute for "Grievance Committee," defeats the purpose of the committee, in that the public does not know what the committee is. He also said that the proposed resolution, he felt, did not put any teeth in the handling of matters of grievance.

On motion of Drs. Geider and Howard, the Council adopted the resolution as read and it is to be presented to the House of Delegates by the chairman of the Council.

New Business

1. *Legislative matters* were discussed by Drs. Wood and Booher, co-chairmen of the Committee on Public Policy and Legislation, and Dr. Clarke.

2. *Indiana A.M.A. Coordinating Committee.* Dr. Nafe, chairman, recommended that this committee be continued next year in view of 1952 being national election year, and that adequate funds be provided for an active campaign against socialism.

3. *Memorial to John F. Hayes.* Mr. Hendricks spoke of the loss of two great men in American medical organization work during the past year—Ray E. Smith and John F. Hayes, who for many years was A.M.A. legislative representative in Washington—and asked that special mention of Mr. Hayes be made in the House of Delegates of the Indiana State Medical Association.

4. *Matters referred to Council by Executive Committee:*

a. *Simplified insurance reporting forms*, submitted and approved by the Council on Medical Service of the A.M.A., and accepted by the Executive Committee, were approved by the Council and referred to the House of Delegates.

b. *Proposed amendment to By-laws concerning investment of surplus funds* was approved and referred to the House of Delegates.

c. *Printing of standing orders for nurses in industry.* On recommendation of the Executive Committee the Council appropriated to the Committee on Industrial Health $290.00 for 10,000 JOURNAL reprints of standing orders for industrial nurses and $150.00 to cover mailing costs for the first year.

5. *American Medical Education Foundation.* Dr. Denny outlined the program of the Committee on Medical Education and Hospitals for a campaign to raise funds for the American Medical Education Foundation and reported that Indiana physicians had contributed $591.00 to date. Dr. Denny's report was accepted on motion of Drs. Mitchell and Clarke.

6. *Remission of state dues* of two members who had been certified by their county medical society secretaries was granted on motion of Drs. Wright and Geider.

7. *Election of* JOURNAL *editors.* On motion of Drs. Mitchell and Geider, Dr. Frank B. Ramsey, Indianapolis, was re-elected editor of THE JOURNAL for 1952, and Dr. A. W. Cavins, Terre Haute, was re-elected associate editor of THE JOURNAL for 1952.

8. *Election of Editorial Board members.* On motion of Drs. Geider and Combs, Dr. Richard H. Miller, Fort Wayne, and Dr. George M. Cook, Hammond, were elected members of the Editorial Board to serve for three years, and to succeed Dr. Raymond F. Carmody, Gary, and Dr. E. L. Cartwright, Fort Wayne.

Date for Midwinter Council Meeting

The Council set Sunday, January 13, 1952, as the date for the midwinter meeting.

Executive Session

On motion of Drs. Howard and Geider, the Council then went into executive session. At the close of the executive session, no further business appearing, the Council adjourned.

THE COUNCIL

(Indianapolis Session, 1951)

Second Meeting

The second meeting of the Council convened immediately following adjournment of the House of Delegates, Wednesday afternoon, October 31, 1951, in the Auditorium of the Athenaeum, Indianapolis, with Dr. W. U. Kennedy, the chairman, presiding. Roll call showed the following present:

Councilors:

First District ..... Paul D. Crimm, Evansville, alternate, and president-elect 1952
Second District ..... William C. Reed, Bloomington
Third District ..... William H. Garner, New Albany
Fourth District ..... George S. Row, Osgood, alternate
Fifth District ..... A. M. Mitchell, Terre Haute
V. Earle Wiseman, Greencastle, alternate
Sixth District ..... W. U. Kennedy, New Castle
Seventh District ..... Roy A. Geider, Indianapolis
Eighth District ..... E. H. Clauser, Muncie
T. R. Hayes, Muncie, alternate
Ninth District ..... Wemple Dodds, Crawfordsville
Tenth District ..... William H. Howard, Hammond
Eleventh District ..... Elton R. Clarke, Kokomo
Twelfth District ..... M. B. Catlett, Fort Wayne
Thirteenth District ..... Kenneth L. Olson, South Bend

Officers:

J. William Wright, Indianapolis, president-elect 1951
Roy V. Myers, Indianapolis, treasurer

Appreciation of A.M.A. Delegate

On motion of Drs. Olson and Dodds, the Council directed that a letter be sent to Dr. A. S. Giordano, thanking him for his services as a delegate from the Indiana State Medical Association to the American Medical Association.

Executive Session

The Council then voted to go into executive session. Following this session, no further business appearing, the Council adjourned.

HOUSE OF DELEGATES

(Indianapolis Session, 1951)

First Meeting

The House of Delegates convened in the Auditorium of the Athenaeum, Indianapolis, at 3:15 P.M., Monday, October 29, 1951, with the president, Dr. Alfred Ellison, of South Bend, presiding.

On motion of Dr. S. J. Petronella, attendance slips signed by the delegates, showing 99 delegates, 12 councilors, 8 ex-presidents, one A.M.A. delegate, the president, and the president-elect present, were accepted in lieu of a roll call.

Dr. William E. Amy, chairman of the Reference Committee on Credentials, announced that a quorum was present, and the chairman declared the House open and ready for the transaction of business.

THE CHAIRMAN: I should announce to you that the By-Laws may be amended at any annual convention by a *majority vote of all delegates present at that convention,* after the amendment has laid on the table for one day.

The House of Delegates may amend any article of the Constitution by a *two-thirds vote of the delegates present at any annual convention,* provided that such amendment shall have been presented in open meeting at the previous annual convention and that it shall have been published twice during the year in THE JOURNAL of this Association.

In Memoriam

The House stood for a minute in tribute to the following physicians, deceased since the 1950 annual session, who were members of the House of Delegates, or who had served the state association in an official capacity:

L. NEFF ASHWORTH, Connersville. Delegate from Fayette County, 1934, 1936, 1938, and 1943; member of Committee on Public Relations 1950-51.

R. H. BAYLEY, Lafayette. Member of Pneumonia Committee, 1939 through 1942.

CURTIS BLAND, Terre Herre. (Formerly Greensburg.) Secretary Decatur County Medical Society 1908; member of Committee on Venereal Diseases 1909 and 1910; delegate to American Medical Association 1910 and 1911.

FRED R. CLAPP, South Bend. Chairman of Medical Section 1921; member Committee on Public Policy and Legislation 1921.

JOHN J. CONNELLY, Terre Haute. (Formerly Rockville.) Secretary Parke-Vermillion County Medical Society 1916, 1917, 1918 and 1923; member of Committee on Control of Cancer 1945, 1946 and 1947.

W. DONALD DAVIDSON, Evansville. Member of Committee on Infantile Paralysis 1948.

BEN E. DUKE, Decatur. Secretary Adams County Medical Society 1935 and 1936. Delegate from Adams County 1935, 1946 and 1949.

H. H. DUTTON, Martinsville. Delegate from Morgan County 1937, 1942 and 1943; secretary Morgan County Medical Society 1941 and 1942; member of Committee on Secretaries' Conference 1942.

K. C. EBERLY, Fort Wayne. Member of Committee on Scientific Exhibit 1916.

E. T. EDWARDS, Vincennes. Secretary of Knox County Medical Society 1918.

C. H. EMERY, Bedford. Member of Committee on Tuberculosis 1907-1908; member of Committee on Compulsory Ventilation 1912-1913.

HUBERT GROS, Delphi. Delegate from Carroll County 1949.

WARREN R. HICKMAN, Logansport. Chairman of Section on Ophthalmology and Otolaryngology 1949.

CHARLES HUPE, Lafayette. Treasurer of Tippecanoe County Medical Society 1902 to 1948.

A. R. KERR, Attica. Secretary of Fountain-Warren County Medical Society 1918, 1942 through 1946.

M. O. KING, Rochester. Secretary of Fulton County Medical Society 1908, 1909 and 1910.

D. A. LEATHERS, Indianapolis. Member of Committee on Arrangements 1910-1911.

O. R. LYNCH, Peru. Secretary of Miami County Medical Society 1916.

G. H. McCASKEY, Winamac. Delegate from Pulaski County 1942.

W. O. McKITTRICK, Washington. Delegate from Daviess County 1943.

L. R. MILLER, Winslow. Delegate from Pike County 1942, 1943, 1945 and 1947; secretary of Pike County Medical Society 1941 through 1947.

B. D. MYERS, Bloomington. Member of Committee on Pathology 1907-1908; chairman of Committee on Medical Education 1908-1909, 1920, and 1922 through 1926, and member of same committee 1910, 1911 and 1912; chairman of Committee on Scientific Demonstrations 1914 and 1915; member of Committee on Health, Public Instruction and Medical Publicity 1916; member of Committee on Public Policy and Legislation 1918 and 1921; member of Committee on Scientific Exhibit 1918 and chairman 1919; chairman of Committee on Medical Education and Hospitals 1927 through 1930; alternate delegate to the American Medical Association 1920 and 1921.

W. E. NICHOLS, Hammond. Secretary of Lake County Medical Society 1925 and 1926; member of Committee on Secretaries' Conference 1926; member of Committee on Industrial and Civic Relations 1927, 1928 and 1929.

F. V. OVERMAN, Indianapolis. Vice-chairman 1928 and 1929, chairman 1931 and 1932, and secretary 1933 of the Section on Ophthalmology and Otolaryngology.

E. E. PADGETT, Indianapolis. Secretary 1921 and chairman 1924 of the Surgical Section; member 1921, 1935 and 1936, and chairman 1925, 1926 and 1937 of Committee on Scientific Work; member of Committee on Arrangements 1924; Seventh District councilor 1927 through 1931; chairman of Council 1930 and 1931; member of Executive Committee 1930, 1931, 1933 and 1934; member of Budget Committee 1931, 1933, 1934 and 1935; President of the association 1934; chairman of Committee on Control of Cancer 1938, 1944 and 1945, and member of the committee 1941, 1942, 1943 and 1946; member of Committee on Medical Education and Hospitals 1939 and 1940.

NETTIE B. POWELL, Marion. Secretary Grant County Medical Society, 1919, 1920 and 1921.

A. L. RATCLIFF, Kingman. Delegate from Fountain-Warren County 1946.

ADA E. SCHWEITZER, Indianapolis. Member of Committee on Scientific Demonstrations 1914 and 1915; member of Committee on Scientific Exhibit 1916 and 1917; member of Committee on Arrangements 1918; member of Committee on Health Problems in Education 1921.

JOHN W. STRANGE, Loogootee. General Practitioner of the Year 1950.

AUSTIN SWEET, Martinsville. Secretary of Morgan County Medical Society 1926 to 1929 inclusive; member of Committee on Diphtheria Prevention 1934 and 1935; member of Medical Relief Committee 1945, 1946, 1947.

L. W. TENNANT, Larwill. Secretary Whitley County Medical Society 1933.

H. R. VANDIVIER, Terre Haute. Member of Sub-Committee to Study Maternal Morbidity and Mortality Rates for Indiana 1941.

ERNEST de WOLFE WALES, Indianapolis. Chairman of Eye, Ear, Nose and Throat Section 1912 and 1913.

W. E. WILKIN, South Whitley. Secretary of Whitley County Medical Society 1924 and 1925.

The House rose a second time in tribute to the memory of Ray E. Smith, executive secretary of the Indiana State Medical Association from May 1, 1946, to August 3, 1951, who passed away on August 4, 1951.

(On motion of Dr. O. T. Scamahorn, duly seconded, the minutes of the 1950 meetings of the House were approved as published in the November, 1950, JOURNAL.)

1951 REFERENCE COMMITTEES

THE CHAIRMAN: In accordance with Chapter X, Section 1, of the By-laws, I have appointed reference committees to serve during this annual convention. I shall read the names of the members of these reference committees and ask that the members please stand as their names are called.

1. **Sections and Section Work:**
   Robert H. Rang, Washington (Daviess-Martin), Chairman
   E. B. Jewell, Logansport (Cass)
   Richard P. Good, Kokomo (Howard)
   Clay Ball, Muncie (Delaware-Blackford)
   G. M. Nie, Huntington (Huntington)

2. **Rules and Order of Business:**
   Virgil McCarty, Princeton (Gibson), Chairman
   G. O. Larson, LaPorte (LaPorte)
   William Karsell, Bloomington (Owen-Monroe)
   M. C. Topping, Terre Haute (Vigo)
   Robert D. Howell, Indianapolis (Marion)

3. **Medical Education and Hospitals:**
   W. C. Wright, Fort Wayne (Allen), Chairman
   V. Earle Wiseman, Greencastle (Putnam)
   J. R. Nash, Albion (Noble)
   R. R. Ploughe, Elwood (Madison)
   T. V. Petranoff, Indianapolis (Marion)

4. **Public Policy and Legislation:**
   Harold C. Ochsner, Indianapolis (Marion), Chairman
   A. S. Giordano, South Bend (St. Joseph)
   R. R. Calvert, Lafayette (Tippecanoe)
   Davis W. Ellis, Rushville (Rush)
   Truman Caylor, Bluffton (Wells)

5. **Publicity:**
   Ray Elledge, Hammond (Lake), Chairman
   Oran A. Province, Franklin (Johnson)
   Robert M. Maurer, Brazil (Clay)
   W. D. Britton, Montezuma (Parke-Vermillion)
   E. E. Shrock, Amboy (Miami)

6. **Hygiene and Public Health:**
   James M. Kirtley, Crawfordsville (Montgomery), Chairman
   George Vail, Lawrenceburg (Dearborn-Ohio)
   W. B. Lybrook, Indianapolis (Marion)
   John S. Hash, Noblesville (Hamilton)
   Max Long, Marion (Grant)

7. **Amendments to Constitution and By-Laws:**
   Augustus P. Hauss, New Albany (Floyd), Chairman
   J. L. Allen, Greenfield (Hancock)
   C. H. McCaskey, Indianapolis (Marion)
   I. E. Huckleberry, Salem (Washington)
   Roy A. Geider, Indianapolis (Marion)

8. **Reports of Officers:**
   S. J. Petronella, East Chicago (Lake), Chairman
   H. P. Ross, Richmond (Wayne-Union)
   H. M. Omstead, Petersburg (Pike)
   Guy B. Ingwell, Knox (Starke)
   Norbert Welch, Vincennes (Knox)

9. **Committee on Credentials:**
   William E. Amy, Corydon (Harrison), Chairman
   Clifford H. Jinks, Indianapolis (Marion)
   Carl F. Briggs, Sullivan (Sullivan)
   W. G. Pippenger, Brook (Jasper-Newton)
   George Seward, North Manchester (Wabash)

10. **Committee on Miscellaneous Business:**
    John M. Paris, New Albany (Floyd), Chairman
    Lee J. Maris, Attica (Fountain-Warren)
    H. T. Combs, Evansville (Vanderburgh)
    Martin C. Heck, Jasper (DuBois)
    Jack Lockhart, Connersville (Fayette-Franklin)

11. **Committee on Prepaid Medical Insurance:**
    William C. Reed, Bloomington (Owen-Monroe), Chairman
    William H. Garner, New Albany (Floyd)
    Charles N. Manley, Rising Sun (Dearborn-Ohio)
    K. N. Venis, Muncie (Delaware-Blackford)
    G. K. Hammersley, Frankfort (Clinton)

To these reference committees will be referred all reports, resolutions, and measures presented to the House at this session, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted at the last meeting of the House on Wednesday, October 31, for acceptance or for rejection. Time will be given at the conclusion of this meeting for the chairmen of these committees to announce the time and place of reference committee meetings.

REPORTS OF OFFICERS

These reports, except for the address of the president and that of the president-elect, are printed in the October JOURNAL and in the Handbook, but each officer will receive five minutes in which to make any additions.

The address of the president, to be given Tuesday evening, will be referred to the Reference Committee on Reports of Officers.

ADDRESS OF PRESIDENT-ELECT

DR. J. WILLIAM WRIGHT: President Ellison, Members of the House of Delegates:

May I at this time reiterate the statement I made at the last annual session of this body, when you honored me with the election as president-elect? I will do all in my power to promote the best interests of this great organization and the best system of the practice of medicine in the world.

I realize that the coming year will be fraught with difficulties, greater perhaps than normally, due to the loss of our beloved Ray Smith.

As co-chairman of your legislative committee for ten years it was my privilege to come in contact with Ray very frequently and to know his extreme interest in the affairs of this organization. Although his earlier training had associated him with the Democratic party, he was held in equally high esteem by leaders in the Republican party, because of one great attribute. His word was good.

Many tributes have been paid to Ray and not one was more lavish than he deserved. He was truly a friend of the people, working as a friend of the best in medicine. We shall miss him greatly.

As I assume the presidency of this association within a few days, I would implore you as representatives of your districts to encourage by word and deed provision for the best and truest medical service to the afflicted, that competent medical care be available around the clock, that unfair charges be exposed, that if there be men who forget their obligations to the public or if there be chiselers, they be dealt with severely, to the end that the free enterprise of medicine be undisturbed and its proven benefits be accessible to all freedom-loving people in these great United States of America.

The profession of medicine is unqualifiedly opposed to every form of regimentation, centralized authority, socialism and its red sister, communism, and to the furtherance of that opposition I pledge my own efforts and solicit your constant support.

(Referred to Reference Committee on Reports of Officers.)

Reports of Executive Secretary, Treasurer, Chairman of Council, and the councilors, were referred to the Reference Committee on Reports of Officers.

REPORTS OF STANDING AND SPECIAL COMMITTEES

THE CHAIRMAN: These reports are printed in the October JOURNAL, and in the Handbook, but each chairman will be allowed five minutes in which to make any additions or explanation to the reports already published, if he so desires.

Executive Committee—Referred to Reference Committee on Reports of Officers.

Constitution and By-laws—Referred to Reference Committee on Amendments to the Constitution and By-laws.

Convention Arrangements—Referred to Reference Committee on Miscellaneous Business.

Industrial Health—Referred to Reference Committee on Hygiene and Public Health.

Medical Education and Hospitals—Dr. James W. Denny, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Medical Education and Hospitals:

The A.M.A. established the American Medical Education Foundation, as an organization to raise and receive funds for the purpose of alleviating the financial ailments of our schools. They even went further by appropriating one-half million dollars of our money to start the campaign, and agreed that every effort would be made to raise the necessary balance through voluntary contribution.

Now, with your indulgence, I would like to give you an up-to-the-minute report *on the failure* that we, as doctors, have made in contributing to this worthy cause. I am sure that after hearing what I am about to say you will give your whole-hearted endorsement to this campaign in our state, and each of you will get your checkbooks out and give a sizeable amount to make this campaign *the success it must be.* I think you will be willing to do even more; I believe each of you will take it upon yourself to talk this campaign up, that you will be responsible for seeing that your respective societies take an active interest in promoting this program to your membership. *We must not fail.*

I will quote verbatim from a report sent us by the A.M.A. The first is a copy of a statement made by Senator James E. Murray, on October 3, this year, during a debate in the Senate on S. 337, the bill for federal aid to medical schools. I quote, "I am glad that the A.M.A. is urging its members every week to individually contribute a *hundred dollars* a year to the support of our medical schools. But, I am sorry to note that during the first 24 weeks of that campaign *less than three one-hundredths* of 1 percent of the country's physicians was in sufficient agreement with the A.M.A.'s position to make such an individual contribution. No, gentlemen, that figure is not an error. For over 6 months the A.M.A. appealed to its members to help solve the critical needs of our medical schools the A.M.A. Way. It asked them to do so each week during that period. On August 4, 1951, *the Journal of the A.M.A.* listed the names of the doctors who had complied. They amounted not to 50 percent of our doctors, gentlemen; not to 5 percent; not to 3 percent; not even 1 percent of the physicians in this country complied. When you add up the list of those who did, you will find it represents approximately point 003, three one-hundredths of one percent of the doctors of America agree with A.M.A.'s leadership as to how that which the A.M.A. itself calls 'A Challenge to the Medical Profession' should be met."

Remember, gentlemen, these are the words of one of the strongest proponents of government health insurance! This is a serious indictment, which has an element of truth in it.

Now I would like to quote an article, again from the A.M.A., and taken from the October issue of *Medical Economics.* "The nation's osteopaths are about to kick off a new big drive for public support. To assist their six struggling schools, they've already raised $4.5 million within their *own ranks.* Now they're shooting for $15 million more from business and the general public, plus another $3 million from within their profession. Special drives will be conducted in cities where osteopathic schools are located: Chicago, Philadelphia, Los Angeles, Des Moines, Kansas City, and Kirksville, Missouri.

"In both funds raised and goals set, the D.O.'s seem somewhat ahead of the M.D.'s. The latter have yet to rustle up their first million within their own ranks, but hope for $5 million in total contributions this year."

Now what have we done in the way of raising funds? *Fifteen Indiana physicians from nine societies have given a total of $591.00 as of October 26, 1951.*

Now what does your committee intend to do? We should not hesitate in the least to set our goal to raise $100,000 per year for the next three years for this worthy cause. That is just a little over twenty-five dollars a year for each member. Contributions for this cause are deductible for taxes. Isn't it better to do it this way, rather than to pay more and more taxes, and at the same time pay for the loss of our freedom through increased taxes? Each of you will receive an appeal from this committee, together with a pledge card.

1. Pledge for three years, if possible.
2. Designate the school you desire your contribution to be paid to, otherwise it will go into the general A.M.A. fund for distribution at their discretion.

3. Talk this program up in each of your local societies.

4. If any of you desire to contribute now, you may see Jim Waggener or me and you will find us in a receptive mood.

Public Policy and Legislation—Referred to Reference Committee on Public Policy and Legislation.

Public Relations—Referred to Reference Committee on Public Policy and Legislation.

Sub-Committee on Physician-Patient Relations—Referred to Reference Committee on Public Policy and Legislation.

Special Committee of the Council on Physician-Patient Relations—Referred to Reference Committee on Amendments to the Constitution and By-laws.

Committee on Publicity—Referred to Reference Committee on Publicity.

Committee on Rural Health—Dr. J. E. Dudding presented the following supplementary report, which, together with the report printed in the Handbook, was referred to the Reference Committee on Public Policy and Legislation:

During the final meeting of the present Rural Health Committee held October 7, 1951, it was the judgment of the committee that we should submit a supplemental report for the purpose of emphasizing and seeking your consideration of several points which we feel important to the future of medicine and our association. As has been pointed out in our printed report, we have carried on a busy program during the past year. One of the most important programs, association-wise, we feel were the regional meetings conducted this spring.

During these meetings representatives of county societies had the opportunity to become better acquainted with the officers of the association, and the officers had the opportunity of hearing first-hand the opinions of our membership. As a result of these very active discussion meetings, we feel the officials of the association have a much better understanding of the thinking of our membership, and conversely we feel the membership has a much better understanding of the aims and programs of the association.

We want to call attention at this time to some of our findings and to urge this house to take them into serious consideration. We would like even to recommend the adoption of some of the recommendations made as a result of these meetings. We feel these items represent the thinking of our membership and present them for your consideration.

1. The regional meetings should be made an annual event and our association officers should be in attendance to hear the views of our membership. In this way, we should strengthen and build our association.

2. As we talked to lay individuals and to our membership, we feel the time has come for the association to re-evaluate its position. We have been injected into politics, we have been criticized for our failure to take an active part in community health programs. Some feel that we have failed to take the proper position of leadership in health movements. Therefore, what is our position today? Shall we take the leadership in promoting health movements? Shall we attempt to accept leadership in developing community, school and rural health programs? Shall we interest ourselves in preventive as well as curative medicine? Shall we proceed to strengthen our organization and be worthy of active participation by our membership in our many endeavors? If we feel medicine should take an active part, then we should chart our course accordingly, if we are to retire to "business as usual tactics," that is another. On the basis of our findings our committee would like to recommend the appointment of a "Little Hoover Commission" within our association to study our operation, and to recommend to this House of Delegates at its next regular meeting, methods in which our association might be strengthened.

3. We would like to recommend to this House that the constitution and by-laws be strengthened in such a way as to obligate our councilors to meet with and discuss with the delegates and officers of the component societies within their district, all matters of business to come before the House of Delegates. This should be done not less than two weeks prior to such meeting of the House of Delegates. We found our members felt they were not adequately informed as to the prospective business of the House and therefore their delegates were not able to act on matters as well informed representatives of their societies.

4. We also found many were questioning the method of electing officers of county, district and state medical organizations. It is therefore recommended that all officers be nominated and elected by secret ballot.

5. We would like to recommend each county society devote at least one program per year or a major part thereof, to a discussion of association activities and affairs.

6. We would also like to recommend a plan be presented to I. U. Medical School whereby prospective students for medical schools be considered not only from a scholastic record but more emphasis be placed upon the community from which the student comes, such

as rural communities, and aptitude for becoming a physician. We feel that it will be impossible to attain a better distribution of physicians among the less populated areas unless more students are enrolled from these areas.

We submit the above recommendations for your serious consideration and recommend the adoption of these points in some form to carry out the intent of the recommendations.

Scientific Exhibits—Referred to Reference Committee on Sections and Section Work.

Scientific Work—Referred to Reference Committee on Sections and Section Work.

Auditing—Referred to Reference Committee on Reports of Officers.

Cancer—Referred to Reference Committee on Hygiene and Public Health.

Chronic Illness—The report of the committee as published in the Handbook, and the following supplementary report, read to the House by the field secretary, were referred to the Reference Committee on Hygiene and Public Health:

The Committee on Chronic Illness has held one meeting during the year. This was a joint meeting with the Governor's Committee on Chronic Illness.

Dr. Caseley gave a report on the Chicago Conference (March, 1951) which was attended by Dr. Carter, Dr. Burney, Mr. Yoho and himself. At this meeting stress was placed upon the preventive aspects of Chronic Illness and brought nationwide focus on early detection, summary of present knowledge with view of using common denominators and provide direction to *all* experts in the field. Community organization must unite medical and allied professional groups with social and economic leaders to better approach the overall problem which involves all strata of the community.

Dr. Anderson demonstrated by charts the changes in the ratio of age groups since 1880 in Indiana. The greatest spread has been in the 30-65 year age group with a steady decline in the early ages and a less but steady increase in the ages over 65 years. It was pointed out by Dr. Burney that since 1900 the total population of the state has doubled while the number over 65 has quadrupled.

Dr. Burney reported on the St. Louis meeting of the International Gerontological Congress attended by Mr. Edwards, Dr. Anderson and himself. Like the Chicago meeting, this gave an opportunity for people of various interests and backgrounds to interchange views and experiences. He was impressed with the results of a rehabilitation service which has been established at the Alleghaney (Pa.) County Home and Home Care programs that have been established in several areas. He commented on the fact that there had been considerable opposition to the suggestion of specialization of nursing homes to care for certain disease entities. The feeling at the Congress was that more emphasis is needed on research in the chronic disease field.

Dr. O'Malley, after briefly describing the administrative duties of the Hospital Council and her division, gave the present status of a contemplated plan of morbidity reporting by the Medical Center and Indianapolis General Hospital. Due to lack of personnel and funds, plans have been stalemated since early in the year. She reported that the Methodist Hospital (Indianapolis) has recently asked for assistance in a case-load study. She said she would prefer studies to be made within the individual hospitals by their own staffs.

After much discussion pro and con, Dr. Caseley recommended that the plans formulated to institute morbidity reporting by selected hospitals be resurrected and studied further. This was seconded by Dr. Carter and carried by consent.

Dr. King presented the need for a person assigned as a liaison with industries and unions to stimulate interest in devising better policies on retirement and to assist employees in better adjustment toward retirement. Post-retirement activities to supply the biological need for action might well be incorporated in such a program.

Dr. Burney recommended that Dr. King should contact management of industries in Indiana to determine their interest or attitude toward such a service to them and make a report concerning the need of further liaison with industry at the next meeting of the committees. Dr. Caseley added the recommendation that organized labor should be contacted on the same basis. The above recommendations were taken by consent.

Mr. Meek: "There has been much interest in Indiana's program at the national level inasmuch as Indiana has been the only state to have the two committees as was recommended by the Commission on Chronic Illness."

The national Commission is interested in defining the common denominators of the chronic illnesses and thereby discover means of attacking the specific diseases as a group. Principal areas have been established as prevention, care, and rehabilitation. Care is most pressing. Primary prevention is the long range goal, but secondary prevention is the real answer at the moment. Common denominator for secondary prevention is early case finding and arresting or "slow-down" of the disease process.

Mass Screening Programs must still be considered as being experimental. The advantages and disadvantages are the same as screening for a single disease except multiplied by the number of tests used.

Advantages—very alluring.

1. More conditions uncovered in more people.
2. Public appeal has been great.

3. Provides needed prevalence figures *if* follow-up is good.
4. Relatively inexpensive to the individuals.
5. Time-saving for physicians.
6. Brings more organizations together to solve the problem.

Disadvantages—are formidable.

1. Few tests are sufficiently reliable and valid.
2. Lack of knowledge of the group being screened with danger of false security.
3. Sample tested may not be representative of total population. Persons may select themselves because of fears, symptoms, family history, etc.
4. Problem of follow-up. No effective mechanism has been devised for a complete report back from either the physician or patient.

Dr. Carter pointed out that certain screening programs have long been accepted. Examples of these are pre-school and school health examinations, pre-employment and the screening program of the Army.

He concluded that he felt that the two committees should go along with proven tests and maintain an open mind regarding tests that are being developed.

Dr. Van Nuys brought to the attention of the group that the Medical Center at present has the beginning of a state-wide rehabilitation program. Limited funds have prevented them from developing the service to the extent that is desired.

Dr. Burney moved that at the next meeting the committees discuss the possibility of establishing a rehabilitation center at the Medical Center with possible future approach towards obtaining state funds. The resolution was taken by consent.

It was moved by Mrs. Nicholson and seconded by Miss Bray that the committee accept the following, which was taken by consent.

WHEREAS, Indiana is the only state at the present which has a Committee on Chronic Illness appointed by the Governor of the state as well as a Committee on Chronic Illness within the Indiana State Medical Association, and

WHEREAS, this conforms with the recommendation of the Commission on Chronic Illness that two such committees coordinate their interests and activities,

Be It Resolved by the members of the Governor's committee that Dr. Alfred Ellison, president of the Indiana State Medical Association, be highly commended for appointing a Committee on Chronic Illness representing the Indiana State Medical Association in this field.

Civil Defense—Referred to Reference Committee on Miscellaneous Business.

Conference of County Medical Society Officers—Referred to Reference Committee on Miscellaneous Business.

Crippled Children Services—Referred to Reference Committee on Public Policy and Legislation.

Diabetes—Referred to Reference Committee on Hygiene and Public Health.

Foot Hygiene—Referred to Reference Committee on Hygiene and Public Health.

Hard of Hearing—Referred to Reference Committee on Hygiene and Public Health.

Heart Disease—Referred to Reference Committee on Hygiene and Public Health.

Indiana A.M.A. Campaign Coordinating Committee—Referred to Reference Committee on Miscellaneous Business.

Indiana Inter-Professional Health Council—Referred to Reference Committee on Miscellaneous Business.

Infantile Paralysis—Referred to Reference Committee on Hygiene and Public Health.

Instructional Courses—Referred to Reference Committee on Sections and Section Work.

Maternal and Child Health—Referred to Reference Committee on Public Policy and Legislation.

Medical and Nursing School Scholarships—Referred to Reference Committee on Medical Education and Hospitals.

Mental Health—Dr. E. Vernon Hahn, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Hygiene and Public Health:

There is a little additional information. I want to report that an open meeting of your committee was held this noon, where representatives of various organizations concerned with the mental health movement—the Indiana Council for Mental Health, the Indiana Mental Hygiene Society, and others—were present.

The new thing is the appointment of Mr. Joe Brown as the full-time director for the Mental Hygiene Society of Indiana. He is a trained, experienced, approved administrator, an administering secretary with success in fund raising. Under his guidance the Mental Hygiene Society proposes to stage a campaign to raise two and a quarter million dollars in Indiana next spring. There is every reason to think they will succeed. They may not reach that goal, but they foresee an interest in foundations, and influential people behind the movement are of sufficient character as to insure a certain measure of success, which means that the Indiana Mental Hygiene Society will be empowered to be a greater influence as an educational organization, a propaganda organization, if you will, in the future, which means that the Indiana State Medical Association should keep a very watchful eye upon the affairs of that society.

That society was really created by the state neuropsychiatrists, so that it might function as an educational propaganda society in the neurological part of our association, but it is highly important that such an organization, with increased power, makes sure it keeps its nose clean, and does not sponsor fantastic ideas and espouse movements which might perhaps be of socialistic import, or lead to some crack-brained invasions of the medical field of psychiatry. Therefore, your committee wishes this House of Delegates to carry back to its constituent societies that each society watch, belong to, participate in, and join with the local chapter of the Mental Hygiene Society, to give it support, guidance, and to keep a watchful eye upon what it does. This is the best insurance that this group does not go off the deep end and lead to all kinds of disturbing invasions into the field of medicine. The best insurance would be for doctors to belong to those chapters in order to influence those societies. It may be helpful if they help support the fund-raising goal, so that it may be a legitimate arm of education. We may prevent some things which might get out of hand, so that this committee will keep the affairs of that society in line. Each of you urge your own society to have an awareness of what goes on in this frothy sort of a field. It will be a good thing for the sound practice of medicine as we see it.

Military Manpower—Dr. John E. Owen, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Miscellaneous Business:

At the last meeting of this committee it was suggested that some figures might help bring the impact of the draft act to the attention of this group. Therefore, I have a few figures. This will not alter the original report except in the total number of doctors.

In 1950 there were 4,134 licensed physicians registered with the State Board of Medical Registration. In the registration completed July 31, 1951, there were 4,130 licensed physicians in the state. This doesn't include physicians who are licensed and not residents in the state. The total number of physicians, in spite of a year under this activity of the federal government in placing physicians with the armed services, has not materially altered the number of physicians. Of this total number of physicians licensed in the state, 50 percent, or 2,067, are registered under the doctor draft law. Of this number there are 176 in priority I. Of the 176 registrants, approximately 22 percent are now on active duty with the armed services. The total number on active duty with the armed services I cannot give you, because the lag in obtaining information about the number of reserves on active duty is between three and four months, according to the different services, but the best estimate is that there are not more than 100 physicians from Indiana on active duty. This would seem to show that unless the war situation changes materially there will not be any great impact on medical care in Indiana.

Committee on Necrology—Referred to Reference Committee on Publicity.

Physician-Hospital Relationship—Referred to Reference Committee on Public Policy and Legislation.

Prepaid Medical and Hospital Insurance—Referred to Reference Committee on Prepaid Medical Insurance.

School Health and Physical Education—Referred to Reference Committee on Hygiene and Public Health.

State Fair—Dr. Malcolm O. Scamahorn, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Publicity:

During the 1951 State Fair over 11,000 persons had their blood pressures taken by the students. While the people attended the exhibit, various literature was handed to them in regard to doctor shortage, socialism, etc. The main interest was in the A.M.A. exhibit on "Quackery" which displayed actual gadgets of quackery. Mr. Larson and Mr. Field of the Bureau of Investigation of the A.M.A. manned the exhibit. The main quackery item was the "Radioclast" machine which had been seized from an Indianapolis chiropractic healer. Several newspaper spreads were obtained in regard to the state association's interest in ridding Indiana of quackery. Our greatest public reception was a fifteen minute interview of Mr. Larson and his presentation of the "Radioclast" on Gilbert Forbes' WFBM-TV news broadcast. The committee wishes to thank the Auxiliary of the Indianapolis Medical Society for its help as hostesses, as well as the exhibit department of the A.M.A.

Traffic Safety—Referred to Reference Committee on Hygiene and Public Health.

Tuberculosis—Referred to Reference Committee on Hygiene and Public Health, except resolution regarding Blue Cross Hospital Service, which is referred to Reference Committee on Prepaid Medical Insurance.

Venereal Disease—Referred to Reference Committee on Hygiene and Public Health.

Veterans Affairs and Rehabilitation—Referred to Reference Committee on Miscellaneous Business.

Journal Editor—Referred to Reference Committee on Reports of Officers.

MEMORIALS

The chairman appointed the following committees to prepare and present, at the last meeting of the House, memorials to:

Ray E. Smith, former executive secretary of the state association: Drs. Cleon A. Nafe, Claude S. Black, and Augustus P. Hauss; and

John F. Hayes, who was associated with the Bureau of Legal Medicine and Legislation of the American Medical Association for many years: Drs. James W. Denny, W. H. Howard, and Alfred A. Thompson.

NEW BUSINESS

1. *Election of Indiana "General Practitioner of the Year."* The chairman of the Council announced that the screening committee appointed by the president had selected the following three physicians for consideration of the House for this award:

D. J. Cummings, Ewing
John T. Kime, Petersburg
A. C. Yoder, Goshen

On ballot vote, Dr. A. C. Yoder, of Goshen, was elected "General Practitioner of the Year."

2. *Supplementary report of Chairman of Council.* Dr. W. U. Kennedy, chairman, presented the following matters which had been adopted by the Council and which were being referred to the House for its consideration:

a. *Resolution on investment of surplus funds,* which was referred to the Reference Committee on Amendments to Constitution and By-laws:

Resolved, That the By-laws of this association be amended by renumbering Chapter XV as Chapter XVI, and to add a new chapter to be known as Chapter XV, to read as follows:

Chapter XV
Investment of Surplus Funds

"All surplus funds of this association shall hereafter be invested only in United States Government bonds or in municipal bonds which the United States Government or the municipalities issuing such bonds shall have the direct obligation to pay."

b. *Resolution to make eligibility to senior membership seventy instead of seventy-five years,* which was referred to the Reference Committee on Amendments to Constitution and By-laws:

Resolved, That Section 4 of Article IV of the Constitution of the Indiana State Medical Association be amended by striking out the word "seventy-five" and substituting in lieu thereof the word "seventy."

c. *Resolution to provide for councilor meetings with county society officers and delegates,* which was referred to the Reference Committee on Amendments to Constitution and By-laws:

Resolved, That the By-laws of the Indiana State Medical Association be amended by adding to Section 1 of Chapter VII the following as an additional paragraph:

"The agenda for each of the first four meetings provided for in this section shall be prepared and distributed to the Councilors at least four weeks prior to the date of each meeting. After receiving such proposed agenda each Councilor shall hold a meeting of the county presidents, secretaries and delegates to the State Convention within his Councilor district, for the purpose of considering the agenda for the meeting of the Council and obtaining the recommendations and views of such presidents, secretaries and delegates, on the subjects contained in the agenda and upon any other subjects which such meetings may decide should be presented in the next meeting of the Council following such district officers' and delegates' meeting."

d. *Recommendation that $5,000.00 be appropriated for the Association's participation the first year in the Indiana Health Foundation,* which was referred to the Reference Committee on Public Policy and Legislation.

e. *Recommendation that student loan fund be discontinued,* which was referred to the Reference Committee on Medical Education and Hospitals.

f. *Approval of A.M.A. simplified insurance reporting forms,* referred to the Reference Committee on Miscellaneous Business.

3. *Resolutions introduced from the floor of the House.*

RESOLUTIONS REFERRED TO THE REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

a. DR. JOHN R. FRANK, Valparaiso:

Subject: Chief of Staff of County Hospitals to be a fifth member on the governing board of county hospitals.

Be It Resolved, That the Indiana State Medical Association sponsor a bill before the General Assembly of Indiana, that would make the Chief of Staff, who is elected annually by the hospital staff, a regular or legal fifth member of the hospital's Board of Governors.

We can see no objection to this proposal. But, there are three advantages:

(1) It would promote better and more cooperative relations between the physicians and the governing board, thus resulting in better service to the patients.

(2) It would forestall and prevent the tendency toward state medicine on the part of the hospitals; in fact, it should prevent unnecessary hiring of physicians and the practice of medicine by hospitals.

(3) The number on the governing board for voting purposes should be an odd number. (*Referenecs*—August and October issues of *Medical Economics*)

b. DR. R. J. MODJESKI, Hammond: *Resolution to allow acceptance of graduates of any A.M.A. approved medical school as interns in Indiana hospitals:*

WHEREAS, there exists throughout the state of Indiana a shortage of graduates of approved American medical schools who are available for service as interns in the hospitals of the state, and

WHEREAS, the shortage is particularly acute in those areas at considerable distances from research and educational centers, and

WHEREAS, the American Medical Association has approved several European and other foreign medical schools, which schools are not now approved by the Indiana State Board of Medical Registration and Examination, and

WHEREAS, graduates of these schools were found to be satisfactory in relieving a similar intern shortage during World War II in many hospitals,

Now Therefore, Be It Resolved that the Indiana State Medical Association, in cooperation with the Indiana State Board of Medical Registration and

Examination, attempt to correct this condition by permitting the use of graduates of any medical school approved by the American Medical Association as interns in Indiana hospitals, and

Be It Further Resolved, that whatever means are required to accomplish this, be they by action of the Indiana Legislature or by modification of the rulings of the Indiana State Board of Medical Registration and Examination, shall in no way be allowed to affect the requirements for a permanent unlimited license to practice medicine in the state of Indiana.

Adopted by the Lake County Medical Society.

c. DR. JAMES W. DENNY, Indianapolis: *Resolution regarding Indiana University School of Medicine and the private practice of medicine:*

WHEREAS, the Indianapolis Medical Society undertook, on the petition of several of its members, an investigation to determine what inroads, if any, the Indiana University School of Medicine had made or is making into the private practice of medicine; and,

WHEREAS, this investigation now has been completed and the report adopted by the Council of the Indianapolis Medical Society which represents more than 800 physicians of the Indiana State Medical Association; and,

WHEREAS, the aforementioned report can be used as a base line for establishment of definitive interpretation of the 1948 agreement entered into by the Indiana University School of Medicine and the Indiana State Medical Association, thereby clarifying the aims and intent of said 1948 agreement; now,

Therefore Be It Resolved, That the attached report of the investigation of the Indiana University School of Medicine, made and approved by the Indianapolis Medical Society, be transmitted to the House of Delegates of the Indiana State Medical Association as a matter of information which may be of interest to the medical profession in Indiana, with suggestion that the report be filed with the records of the State Association.

RESOLUTIONS REFERRED TO THE REFERENCE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

a. DR. LOWELL F. BEGGS, Columbus: *Resolution directing study of laws pertaining to care and treatment of alcoholics and proposing appropriate legislation:*

WHEREAS, chronic alcoholism is a serious problem in every community;

WHEREAS, inadequate study and treatment has been given to these individuals; and,

WHEREAS, other states are actively studying the problem and passing legislation for the care and treatment of chronic alcoholics;

Resolved, That the legislative committee of the State medical association, with the assistance of such additional physicians as the president of the association may in his discretion appoint as advisors to said committee, be, and hereby are, instructed to make a preliminary study, with the help of the attorney for the association, of the relevant facts existing in the state of Indiana, and of the laws now existing in other states, pertaining to the methods through which the care and treatment of chronic alcoholics may be provided for, through the utilization of the increasing scientific knowledge applicable to such problems; and that if the said committee and its advisors and the attorney deem it in the interest of the public, they draft a bill for introduction into the next session of the legislature embodying the results of their study, the bill to be drafted during the year 1952, in time for copies to be presented for consideration in a meeting of the council not later than the July meeting.

b. DR. H. R. STIMSON, Gary: *Resolution on reciprocity with Illinois, Ohio, Michigan and Kentucky:*

WHEREAS, there exists today in the medical practice statutes of the states of Indiana, Illinois, Ohio, Michigan, and Kentucky, considerable variation regarding the requirements for licensure of physicians, and

WHEREAS, further wide variation exists in the reciprocity regulations of the Boards of Medical Registration in each of the various states with regard to licenses tendered from one to another, and

WHEREAS, these variations result in considerable confusion and hardship to men practicing medicine close to the borders of the state of Indiana, in some instances even jeopardizing the legal position of those physicians when attempting to care for their patients, now, therefore,

Be It Resolved, That the Indiana State Medical Association in cooperation with the Indiana State Board of Medical Registration and Examination seek, through conference with the corresponding organizations in the states of Illinois, Ohio, Kentucky, and Michigan, to arrive at uniform agreements governing the issuance of licenses to practice medicine and regulations regarding reciprocity between each of the several states, and

Be It Further Resolved, That failing such agreement, the State of Indiana independently shall amend its own regulations in such manner as required to assure Indiana physicians that their interests with respect to practice in the states bordering on it are at least equal to the privileges accorded the physicians licensed in these other states with respect to their practice in the state of Indiana.

Adopted October 7, 1951, by the Lake County Medical Society.

c. DR. J. P. VYE, Gary: *Resolution regarding A.M.A. assuming responsibility for standardization of professional practice at hospitals:*

WHEREAS, the members of the Lake County Medical Society have long felt that the American Medical Association, as the governing body of organized medicine, should perform the functions of standardizing hospitals previously handled by the American College of Surgeons, and

WHEREAS, in 1950, without consultation with the American Medical Association, the American College of Surgeons entered into negotiations to turn over this function in its entirety to the American Hospital Association, which is a layman's organization not bound by the oath and tradition of American Medicine, and

WHEREAS, at the interim session of the American Medical Association, this subject did not reach the floor of the House of Delegates, and

WHEREAS, rumors of a compromise agreement with the American Hospital Association still persist, and

WHEREAS, the division of responsibility between the medical profession and the American Hospital Association would be a blow to the medical control of hospitals, now, therefore,

Be It Resolved, That the delegates of the Lake County Medical Society to the House of Delegates of the Indiana State Medical Association assembled in Indianapolis on October 29, 30, and 31, 1951, urge that the American Medical Association, the organization representative of all doctors, assume full responsibility for the standardization of professional

practice at hospitals, and that its committee for this purpose include specialists, general practitioners, and medical educators, and

Be It Further Resolved, That the delegates of the Indiana State Medical Association to the House of Delegates of the American Medical Association bring this matter to the floor for discussion in an effort to cause the American Medical Association to assume this responsibility independent of all other organizations.

Adopted October 7, 1951, by the Lake County Medical Society.

RESOLUTION REFERRED TO REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

DR. M. I. HEWITT, South Bend: *Resolution requesting formation of Section on Preventive Medicine and Public Health:*

WHEREAS, the members of the Indiana Health Officer's Association are members in good standing of the Indiana State Medical Association and its component County Medical Societies, and

WHEREAS, the health officers believe that the best interests of medicine and public health will best be served by a close liaison between the doctors in private practice and those engaging in public health work, full-time or part-time, and

WHEREAS, active participation in public health work including school health is a responsibility of the medical profession, and

WHEREAS, the medical problems in public health are the problems of our profession,

Be It Resolved, That the members of the Indiana Health Officer's Association request the Indiana State Medical Association to form a section on Preventive Medicine and Public Health in order that we may participate in the affairs of the Association for the consideration of medical problems related to all phases of medicine and public health and reassert the leadership and guidance of the profession in handling these problems.

RESOLUTIONS REFERRED TO THE REFERENCE COMMITTEE ON AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

a. DR. HAROLD C. OCHSNER, Indianapolis: *Resolution to give each section a delegate in the House of Delegates:*

WHEREAS, there is a growing interest in the various sectional activities of the Indiana State Medical Association; and,

WHEREAS, it is felt that the particular scientific and business problems of the various sections need special representation in the House of Delegates of the Indiana State Medical Association; and,

WHEREAS, the American Medical Association's House of Delegates seats delegates from its scientific sessions because it feels that they can best present the problems of the respective sections;

Therefore, Be It Resolved, That Clause 1 in Article V of the Constitution of the Indiana State Medical Association be amended to read as follows: "(1) Delegates elected by the component county societies and by the scientific sections."

Be It Further Resolved, That Chapter III of the By-Laws of Indiana State Medical Association be amended by adding thereto an additional section to be numbered Section 3, and by renumbering Sections 3 and 4 as Sections 4 and 5 respectively; and that the new section to be numbered Section 3 shall read as follows:

"Sec. 3. A Delegate to be seated in the State Association House of Delegates shall be elected by each section at the Annual Convention. He shall have the same rights, privileges and duties as other Delegates. His term of office shall be for two years. He shall be a member of the Association who would not, except for such election, be a member of the House of Delegates. He shall be eligible for re-election as long as he remains a member of the section from which he was elected and of the State Association, but he shall not serve for more than six consecutive years."

b. DR. RALPH V. EVERLY: *Resolution on reorganization of Councilor Districts to conform with Congressional Districts, requiring a change in By-laws:*

WHEREAS, the organization of the Indiana State Medical Association is on a basis of thirteen districts which do not, in most instances, coincide geographically with the eleven congressional districts of the state; and,

WHEREAS, officers and executive employees of the State Association have found that there is an increasing amount of confusion in the conduct of the affairs of the Association as a result of the overlapping of medical districts into congressional districts and it is pointed out that in one instance a medical district overlaps three congressional districts; and,

WHEREAS, it is increasingly important, due to latter day developments, that a clear and close working liaison be maintained with a minimum of confusion between the State Association and governmental and business men and agencies of the congressional districts; and,

WHEREAS, such liaison now is made extremely difficult because of the confusion in the minds of the laity regarding congressional and medical districts; and,

WHEREAS, the purpose behind the original thirteen medical districts now has been outmoded to the point where the structure is cumbersome; now, therefore,

Be It Resolved, That the House of Delegates, acting on the authority vested in it by Article VII of the Constitution of the Indiana State Medical Association, hereby orders that the state be organized into the same number of Councilor Districts as there are Congressional Districts, and that the boundary lines of the Councilor Districts be the same as the boundary line of the Congressional Districts—except that where the boundary line of a Congressional District runs through any county instead of on a county boundary line the entire county thus divided as to Congressional Districts shall be included in that Councilor District in which is included the part of the county having the largest population; that on any change in the number of Congressional Districts or in the boundaries thereof, the same changes, subject to the exception just stated, be made in the Councilor Districts of the state; that councilors elected from the districts heretofore defined shall serve to the end of the terms for which they respectively have been elected; that where two or more present councilors come from the same district, under this resolution for redistricting, the last one elected from such new district prior to the time of the adoption of this resolution shall be the District Councilor, and the remaining councilor, or councilors, from that same district shall be Councilors at Large; that if under the districts created by this redistricting any district would be without a councilor the county societies in such district shall be, and hereby are, authorized to hold a meeting to be called by the Executive Secretary of the Indiana State Medical Association at a time and place to be fixed by conference or correspondence with the sec-

retaries of the counties within such district for the election of a District Councilor and such other district officers as they deem necessary to complete the organization of such district; that when the respective terms of office of those who under this resolution become Councilors at Large expire, such offices shall cease to exist, Provided: That this resolution shall not take effect until the Constitution of this Association shall have been duly amended in such a manner as to make this resolution consistent therewith.

c. DR. RALPH V. EVERLY: *Resolution on reorganization of Councilor Districts requiring Constitutional amendment:*

Resolved, That Article IX, Section 1, of the Constitution of this Association be amended to read as follows:

"Section 1. The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and the same number of Councilors each year as there are of Congressional Districts in the state of Indiana—each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member."

Be It Further Resolved, That wherever the *unqualified* word "Councilors" is used anywhere in the Constitution and in the By-Laws of this Association the entire number of Councilors referred to shall be the number provided for in Article IX, Section 1, of the Constitution as amended by the foregoing paragraph of this Resolution.

d. DR. M. B. CATLETT: *Resolution to abolish office of Alternate Councilor:*

Resolved, That Article IX of the Constitution of the Indiana State Medical Association be amended by striking out Section 5 thereof, and by renumbering the remaining sections accordingly.

e. DR. ROY A. GEIDER, Indianapolis: *Resolution providing for a mid-year meeting of the House of Delegates.* The following resolution is introduced by the Seventh District Society:

Resolved, That the By-Laws of the Indiana State Medical Association be amended by adding to Chapter IV thereof an additional section to be numbered Section 7, which shall read as follows:

"Section 7. In addition to the meetings provided for in Section 1 of this Chapter IV, a meeting of the House of Delegates shall be held each year as nearly as is conveniently possible, six months after the last meeting provided for in said Section 1. The date and place of this meeting shall be fixed by the Council in its regular January meeting of each year, and notice thereof shall be published in the next JOURNAL of the association. Not less than thirty days before such meeting, written notices shall be sent to all Delegates, in which notices shall be included the agenda for the meeting, on which agenda shall be a statement of each item to come before the meeting so far as is known to the Executive Secretary at the time the said notices are prepared for mailing. After the business listed on the agenda has been disposed of in the meeting, new business presented in the form of resolutions or motions from the floor will be considered and disposed of."

f. DR. M. C. TOPPING, Terre Haute: *Resolution to make Committee on Conference of County Medical Society Officers a standing committee:*

Resolved, That Chapter VIII of the By-Laws of Indiana State Medical Association be amended by adding thereto a new section to be known as Section 12 and renumbering the present Section 12 as Section 13: and that the new Section 12 read as follows:

"Section 12. The Committee on Conference of County Medical Society Officers shall consist of seven appointive members. It shall have the duty of arranging for conferences of County Medical Society Officers, preparing the agenda therefor, and fixing the time and place for such meetings."

g. DR. W. U. KENNEDY, New Castle: *Resolution which would make Committee on Physician-Patient Relations a standing committee and outlining its composition and duties:*

Be It Resolved, That Chapter VIII of the By-Laws be amended by adding thereto Sections 13 and 14, which sections shall read as follows:

"Section 13. A standing committee to be known as 'The Board of Appeals on Patient-Physician Relations' shall be composed of nine physicians, three of whom shall be past presidents of the association, and all of whom shall be appointed by the president of the association. Not more than one physician shall be appointed from any one Councilor District. No member shall hold any elective office in the state association during tenure on this committee. Of the nine physicians first appointed, three, including one past president, shall serve for a period of one year; three, including one past president, for two years; three, including one past president, for three years. Thereafter three shall be appointed each year for a three year term, to fill the vacancies caused by the expiration of terms. Any vacancy occurring in this committee other than by expiration of terms shall be filled by an interim appointee to serve the balance of the unexpired term. This committee shall organize itself by electing a chairman, vice-chairman, and secretary.

"Section 14. The duties of this Board of Appeals on Patient-Physician Relations shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians. It may, if it believes the facts justify such action, cite the member to the Council of the state association. It shall, subject to the approval of the Council, draw up a set of rules and regulations governing the procedures and official actions of the Board."

h. DR. TRUMAN E. CAYLOR, Bluffton: *Resolution providing method for election of chairman of Council and chairman of Executive Committee:*

I move that the following resolution be adopted:

Resolved, That the election of the Chairman of the Council be by secret ballot and in the following manner:

(a) That each councilor write on a blank ballot, furnished by the Executive Secretary, the name of the person he favors for the chairmanship.

(b) That these ballots be collected by the Secretary and counted openly by a Committee of Tellers appointed by the chairman.

(c) That if any one receives a majority of all the ballots cast, he be declared elected; but that if no one receives a majority, then all names except the two who have received the two highest number of ballots in the first voting be dropped from further voting and another secret ballot in like manner be cast with only the said two persons as candidates;

and the one receiving the largest number of votes in the last voting be declared the Chairman.

Be It Further Resolved, That the Chairman of the Executive Committee be elected by a secret ballot in the same manner.

RESOLUTIONS REFERRED TO THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

a. DR. LESTER D. BIBLER, Indianapolis: *Resolution regarding Veterans Hospitals:*

WHEREAS, Veterans Hospitals are accepting non-service connected disability cases among veterans; and the acceptance of such cases indicates the developing of a policy among Veterans Hospitals of accepting hospital benefits paid by commercial insurance companies and thereby enlarging the activities of such hospitals beyond the purpose for which they were built, which might result in the overcrowding of veteran's facilities to the disadvantage of veterans suffering from service connected disabilities; and,

WHEREAS, the use of Veterans Hospitals and other government facilities for the treatment of veterans suffering from non-service connected disabilities would tend to reducé the public patronage of local non-government hospitals and medical facilities to the general disadvantage of the public at large; and,

WHEREAS, this practice would introduce unfair competition of such government agencies with the local agencies, and if permitted to develop widely would produce a result detrimental locally and nationally to both the government and the non-government agencies.

Therefore, Be It Resolved, That the House of Delegates of the Indiana State Medical Association strongly disapprove of this procedure on the part of Veterans Hospitals.

Be It Further Resolved, That a copy of this resolution be sent to each Representative and Senator of Indiana, the Veterans Administration National Offices, American Hospital Association, American Medical Association, each State Medical Society, and the Indiana Association of Insurance Underwriters.

b. DR. MAURICE V. KAHLER, Indianapolis: *Resolution on Blue Cross-Blue Shield cooperation with Veteran's Administration:*

WHEREAS, Veterans of this state are unable to obtain the Physicians and Hospitals of their choice for treatment of their service connected disabilities except at their own expense, and

WHEREAS, In the state of Michigan, Veterans have access to Physicians and Hospital facilities of their choice for treatment of their service connected disabilities and the physicians and Hospitals are compensated by the veterans administration through the facilities of the Michigan Blue Cross and Blue Shield organization, and

WHEREAS, In the state of California, a similar arrangement exists between the California Physicians and Hospitals and the California Physicians Service organization, and

WHEREAS, A satisfactory Patient-Physician relationship is maintained in keeping with the high ideals of American Medicine under this plan in both Michigan and California, and

WHEREAS, The Indiana Blue Cross and Blue Shield organization are now in a position to assist in such a program, therefore be it

Resolved, That the Indiana State Medical Association take steps to adopt a similar arrangement with the Veterans Administration to provide compensation to the Physicians and Hospitals through the facilities of the Indiana Blue Cross and Blue Shield Organization so that the Veterans may have a free choice of Physicians and Hospitals for his or her service connected disability.

c. DR. M. B. CATLETT, Fort Wayne: *Resolution on use of "M.D." instead of "Dr.":*

WHEREAS, chiropractors, osteopaths, veterinary doctors and members of the clergy are addressed "Dr."

WHEREAS, much of our mail from the state medical society and the A.M.A., and all medical correspondence is addressed "Dr."

Be It Resolved, That this association do all in its power to have mail addressed "M.D."

d. DR. O. T. SCAMAHORN, Pittsboro: *Resolution on deferral of chiropractic students:*

WHEREAS, it has been reported that on September 27, 1951, under the Universal Military Training and Service Act, a regulation was promulgated under which students of chiropractic were made deferrable on the basis that they were students of a healing art and should be included among deferrable students, such as students of engineering, chemistry, medicine, dentistry, and other scientific subjects; and,

WHEREAS, other students who are made deferrable must be students of recognized schools and colleges maintaining standards of sound educational merit, while no school of chiropractic exists in America that maintains educational standards the equivalent of the standards maintained in the other schools in which deferrable students are enrolled; and,

WHEREAS, it has been scientifically demonstrated that chiropractic is without merit as a healing art and that no school of chiropractic gives training adequate to prepare any of its students for service useful to mankind as practitioners of any art of healing; and,

WHEREAS, chiropractors, without first acquiring or attempting to acquire adequate preparation in the nature of true scientific study, are continuously engaged in an effort to obtain unmerited recognition in the Armed Forces and the civilian population of the United States as properly trained practitioners of a healing profession, and are trying to accomplish their purpose solely through lowering the standards of education and training presently required for such recognition; and,

WHEREAS, heretofore no recognition has been given to chiropractors in the Armed Forces of the United States, and chiropractic services are not used in treating wounds or diseases in the public health services nor in the Armed Forces of the United States; and,

WHEREAS, whatever is done to lower the standards of medical care, either in the Armed Forces or in the civilian population, is against the best interests of the public and for that reason should be vigorously opposed and resisted; and,

WHEREAS, anything that is done by the Government, which may be construed as something in the nature of recognition of merit in chiropractic, will certainly be immediately seized upon and used by chiropractors for propaganda purposes in behalf of their own commercial interests but to the disadvantage of the public.

Therefore, Be It Resolved, That the Indiana State Medical Association hereby protests against any regulation under which students of chiropractic may be deferred on that ground under the Universal Military Training and Service Act; that the Association recommends that chiropractic students be eliminated from the groups which are deferrable under that law; that the Indiana delegates to the American Medical Association be, and hereby are, instructed to present to the next meeting of the House of

Delegates of the American Medical Association a resolution of the same nature as this one, and work for its adoption; and,

Be It Further Resolved, That a copy of this resolution be mailed to the president of the American Medical Association and to the presidents of the various State Medical Associations; and also to the members of the Senate and House of Representatives from the state of Indiana, to the Surgeon Generals of the United States, to the Secretary of Defense of the United States, and to the President of the United States.

No further business appearing, the House of Delegates adjourned, to meet again at 11:30 a.m., Wednesday, October 31, 1951, in the Auditorium of the Athenaeum.

HOUSE OF DELEGATES

(Indianapolis Session, 1951)

Second Meeting

The second meeting of the House of Delegates, a luncheon meeting, was called to order by Dr. Alfred Ellison, president, in the Auditorium of the Athenaeum, Indianapolis, at 11:55 a.m., Wednesday, October 31, 1951.

Dr. William E. Amy, chairman of the Reference Committee on Credentials, called the roll, showing 97 delegates, 11 councilors, 9 ex-presidents, the president, president-elect and the treasurer present.

ELECTION OF OFFICERS

Election of officers resulted as follows:

President-elect, 1951-52	Paul D. Crimm, Evansville
Treasurer	Roy V. Myers, Indianapolis
Assistant Treasurer	John M. Whitehead, Indianapolis
Delegates to A.M.A., for term expiring December 31, 1953	F. S. Crockett, Lafayette Wendell C. Stover, Boonville
Alternates	Robert H. Rang, Washington Cleon A. Nafe, Indianapolis

DR. PAUL D. CRIMM, President-elect: Mr. President, fellow practitioners of the healing art: No doubt Minor Miller, the old king-maker, thanks you, the other delegates thank you, and I thank you. In spite of the fact that the Vanderburgh County Medical Society had to scrape the "bottom of the barrel" for a candidate, count on me to do my level best, for our patients, for you physicians, and for everybody's free enterprise. Under the tutelage of these gentlemen on the rostrum and the Council, I hope to maintain for you that fearless and honest leadership which has long paralleled the achievements which the Indiana State Medical Association has made in behalf of the noblest of all professions, namely, the art and the practice of medicine. Thank you.

ELECTIONS OF COUNCILORS

Elections of councilors to replace those whose terms will expire December 31, 1951, were reported as follows:

2nd District—Arthur G. Blazey, Washington
5th District—M. C. Topping, Terre Haute
8th District—F. E. Keeling, Portland
11th District—Elton R. Clarke, Kokomo, reelected

PLACE OF 1953 ANNUAL SESSION

On motion of Drs. Elmer C. Singer and J. W. Denny, the House accepted the invitation of the Orange County Medical Society to meet at French Lick in 1953.

AMERICAN MEDICAL EDUCATION FOUNDATION

Dr. J. W. Denny, chairman of the Committee on Medical Education and Hospitals, told of the meeting which his committee held on Tuesday, October 31, 1951, and the procedure to be followed in an effort to raise $100,000.00 for the American Medical Education Foundation. He stressed the importance of participation of all Indiana physicians in this endeavor. Distribution of pledge cards among the delegates resulted in a total of $7,160.00 being donated or pledged. On motion of Dr. Denny, seconded by many, this year's Medical Education Fund is to be called "The Ray E. Smith Memorial Fund."

REPORTS OF REFERENCE COMMITTEES

SECTIONS AND SECTION WORK

DR. ROBERT H. RANG, chairman, presented the following report, which, on motion of Dr. Rang, duly seconded, was adopted:

(1) *Committee on Scientific Exhibits*

The committee has examined the scientific exhibits and commends Dr. Caseley and his committee and the individual exhibitors for the excellence of the displays and for the intelligence and labor which obviously were necessary to their preparation.

(2) *Committee on Instructional Courses*

The report of the Committee on Instructional Courses was read, and we recommend that it be accepted as submitted. Specific favorable notice was taken of the fact that for the first time these courses will be accepted as credit in postgraduate training by the Indiana Academy of General Practice. Drs. Batman and Sage and their committee, and the individual instructors have continued the high standard of this valuable and popular feature of our annual convention.

(3) *Committee on Scientific Work*

We wish to commend Doctor Culbertson and his committee for the excellent scientific program and to thank the speakers for the effort they expended and the information we received.

The committee regrets that, as in past years, the attendance at scientific programs in general was far below that which the calibre of the speakers deserved. While it is not within the province of this committee to make specific recommendations in this connection, a number of proposals were discussed, and it was felt that im-

provement would not be impossible of attainment. One area in which this might be accomplished is a re-alignment of the time relationships between business, scientific and social components. The discussion led to the conclusion that the re-establishment of section scientific programs could be so devised as to increase the attendance at general scientific programs.

I move the adoption of this report.

ROBERT H. RANG, M.D., *Chairman*
E. B. JEWELL, M.D.
RICHARD P. GOOD, M.D.
CLAY BALL, M.D.
G. M. NIE, M.D.

RULES AND ORDER OF BUSINESS

DR. VIRGIL McCARTY, chairman, presented the following report, which, on motion of Dr. McCarty, seconded by several, was adopted:

Your Reference Committee on Rules and Order of Business met. No business was referred to this committee and no change in order of business is being recommended at this time.

Due to the ever-increasing amount of business coming before the annual meeting of the House of Delegates and the obvious inability of the House to give these matters full consideration, your committee urges serious thought be given to the proposed changes in the by-laws providing for an interim session of the House of Delegates.

VIRGIL McCARTY, M.D., *Chairman*
G. O. LARSON, M.D.
WILLIAM KARSELL, M.D.
M. C. TOPPING, M.D.
ROBERT D. HOWELL, M.D.

MEDICAL EDUCATION AND HOSPITALS

DR. WILLIAM C. WRIGHT, chairman, presented the following report, which was adopted section by section and as a whole, on motion of Drs. Wright and George R. Daniels:

(1) The Reference Committee on Medical Education and Hospitals wishes to commend the standing Committee on Medical Education and Hospitals for its work in initiating the program of postgraduate education by telephone seminar. Our committee recommends continuation of these seminars.

With reference to the supplementary report having to do with A.M.A. Educational Foundation —it is evident from this report that the membership has not been fully awake to their responsibilities. We strongly urge that those who are interested in medical freedom accept more of the financial responsibilities for such. We, therefore, endorse the personal solicitation program that Dr. Denny and his committee has given us to raise funds for this project.

(2) With reference to the report of the Committee on Medical and Nursing School Scholarships it is the consensus of our committee that financial assistance to student nurses or medical students, either through scholarships or loans, have been difficult to administer and have not accomplished the purposes for which they were intended. We accept the committee's recommendation, together with that of the Council, that this activity be discontinued.

(3) In reference to the resolution that the Indiana State Medical Association sponsor a bill making the chief of staff of a county hospital a regular fifth member of the Hospital Board of Governors, we fully endorse the idea as set forth in this resolution as being in the best interest of the medical profession and the hospitals.

(4) In reference to the resolution having to do with the use of unlicensed interns of schools approved by the A.M.A. in our hospitals, we do not feel that we are sufficiently informed to act upon this resolution and suggest that a committee (in consultation with the association's attorney) be formed to study the situation to clarify same.

(5) In reference to the resolution of the Indianapolis Medical Society concerning the investigation to determine the inroads, if any, the Indiana University School of Medicine has made or is making into the private practice of medicine, we concur with the suggestion that the report be filed with the state association.

W. C. WRIGHT, M.D., *Chairman*
V. EARLE WISEMAN, M.D.
J. R. NASH, M.D.
R. R. PLOUGHE, M.D.
T. V. PETRANOFF, M.D.

PUBLIC POLICY AND LEGISLATION

DR. HAROLD C. OCHSNER, chairman, presented the following report, which was adopted section by section, and as a whole, on motions of Dr. Ochsner, with seconds, as noted:

We commend the Committee on Public Policy and Legislation for its diligent, untiring and constructive work in the Assembly and on the national scene. Their work on the chiropractic bill has been particularly outstanding. We hope that they will continue to interest more physicians in legislative activity. Mr. President, I move the adoption of this report. (Seconded by several.)

We commend the Committee on Public Relations for its excellent work and in particular for the most valuable and up-to-the-minute information communicated to the membership through the ISMA News Flashes. We would emphasize in particular the continued need for close liaison with labor and would cite the work that has been done in South Bend, as an example. Mr. President, I move that this portion of the report of the reference committee be adopted. (Duly seconded.)

We wish to express appreciation to the Sub-Committee on Physician-Patient Relations for its most helpful work in furthering better physician-

patient relationships. Due to the extreme importance of the work of this committee we would concur with them and commend to the House the recommendation that the committee be enlarged and made a standing committee. (Motion for adoption duly seconded.)

We wish to accept and to commend to the House the resolutions (page 30 of the Handbook), proposed by the Committee on Physician-Hospital Relationships with certain minor changes:

(Reference committee changes italicized.)

Therefore, be it resolved that:

1. The work on the aims of this committee be continued, and

2. The Indiana State Medical Association urge physicians to settle their differences with hospital management by conferences at the local level, *and* through *such* proper *mcehanism as is set forth in the Hess report.*

3. The House of Delegates specifically instruct the Board of Directors of Mutual Medical Insurance to arrange for coverage of the medical services of the anesthesiologists, radiologists and pathologists in hospitals under the Blue Shield Plan at the earliest feasible time as a matter of absolute necessity in protecting the ethical standards of our professions. *We would furthcr urge this House of Delegates to make every effort to pcrsuade the Mutual Medical Insuranee Company to turn over to Blue Shield, or the Mutual Medical Insurance Company, the professional services that they originally promised to turn over to it, services of anesthesiologists, pathologists and radiologists.*

(Motion for adoption of this section seconded by Dr. Kenneth Olson.)

We would accept and commend to the House the following resolutions (page 22 of the Handbook), adopted by the Committee on Crippled Children Services:

Be It Resolved, That we recommend to responsible agencies dealing with medical care of the indigent crippled (The Indiana Department of Public Welfare, National Foundation for Infantile Paralysis, Indiana Division of Vocational Rehabilitation, and similar organizations), to establish a uniform means test formulary for their clientele, and when adopted, it be used throughout the state.

We recommend to the Indiana Hospital Association that its members set up such hospital admittance procedure that upon the chart of the crippled indigent person it will show whether he or she has medical, surgical or industrial insurance. And furthermore, all patients who have hospital, medical and surgical insurance should be considered as nonindigent unless financial distress can be definitely established.

Cognizant of the serious implications of the problems of the cardiac cripples, *be it resolved* that further investigation of case finding techniques, be encouraged.

(Motion for adoption duly seconded.)

We concur with the Committee on Maternal and Child Health in not opposing at this time a revised EMIC program. We endorse the work that the committee has done with the Medical Advisory Committee of the Indiana Society for the Prevention of Blindness. We commend the committee for its diligence in promoting the establishment of a training center for nurses in the care of premature infants at Indiana University. We confirm its approval of the Brown County Public Health Nursing and Nurse-Midwife Service, as well as the Brown County Health Center. (Motion for adoption of this section seconded by Dr. A. S. Giordano.)

We accept and commend to the House three recommendations proposed by the Committee on Rural Health as published on page 19 of the Handbook, with the addition, as suggested in their supplementary report, of this sentence (italicized) to paragraph No. 1:

1. Conferences be continued to bring out the thinking of physicians in rural areas. This will also show up potential leaders in the various communities. *The regional meetings should be made an annual event and our association officers should be in attendanee to hear the views of our membership.*

We would recommend that the chairman of the Rural Health Committee appoint from within the committee, a subcommittee to study ISMA operations in rural health. We feel that the Indiana Foundation for Health which was proposed represents too big a project for consideration at this time. We would commend this to the Rural Health Committee and to the ISMA Council for further study. The Committee on Rural Health is to be complimented on its intelligent thinking on extensive over-all planning. (Motion for adoption of this section seconded by Dr. Olson.)

We feel that the Council and the Committee on Rural Health should give further thought to the appropriation of $5,000.00 toward the Indiana Health Foundation, particularly in view of the fact that certain other organizations have found it impossible to contribute proportionate amounts. (Motion for adoption of this section seconded by Dr. H. P. Ross.)

Your reference committee feels that paragraph No. 6 of the Rural Health Committee's supplementary report, which has to do with enrollment of prospective medical students, is a matter for consideration of the Reference Committee on Medical Education and Hospitals and we suggest that this item be referred to that committee. (Motion for adoption of this section seconded by Dr. W. Dodds.)

We approve of the resolution concerning alcoholics and recommend to the House that the president be empowered to appoint a committee for preliminary study of this problem. (Motion for adoption of this resolution duly seconded.)

We urge the House to empower the executive secretary to communicate with the executive secretaries of bordering states and to urge upon them consideration of revision of their attitude toward Indiana physicians. We do not feel that punitive measures should be taken against bordering states, particularly in view of the fact that this would necessitate statutory revisions of our own medical

registration act. (Motion for adoption duly seconded.)

We feel in regard to the resolution from Lake County regarding A.M.A. assuming responsibility for standardization of professional practice at hospitals, that since the problem is in process of solution, no action be taken at this time. We would urge the House to recommend to the A.M.A. that in the choice of representatives on the Hospital Standardization Commission, all branches of the practice of medicine be adequately represented. (Motion for adoption of this section seconded by Dr. L. D. Bibler.)

HAROLD C. OCHSNER, M.D., *Chairman*
A. S. GIORDANO, M.D.
R. R. CALVERT, M.D.
DAVIS W. ELLIS, M.D.
TRUMAN E. CAYLOR, M.D.

Mr. President, I move the adoption of the entire report. (Seconded by Dr. George R. Daniels.)

PUBLICITY

DR. RAY ELLEDGE, chairman, presented the following report, which was adopted on motion of Dr. Elledge, seconded by several:

The Reference Committee on Publicity met and reviewed the reports of the Committees on Publicity, Necrology and State Fair. The reference committee commends these committees on the work covered and accomplished. It recommends the adoption of the reports as published in THE JOURNAL and also the supplementary report submitted by the State Fair Committee.

RAY ELLEDGE, M.D., *Chairman*
ORAN A. PROVINCE, M.D.
ROBERT M. MAURER, M.D.
W. D. BRITTON, M.D.
E. E. SHROCK, M.D.

HYGIENE AND PUBLIC HEALTH

DR. JAMES M. KIRTLEY, chairman, presented the following report, which was adopted section by section, and as a whole, on motions of Dr. Kirtley, with seconds by those indicated:

1. The Committee on Industrial Health is to be commended for the completion of the project "Medical Direction for the Nurse in Industry." We subscribe to their recommendation that this be published in book form by the state association, to be distributed to all doctors in industrial plants, and made available to all nurses interested in industrial work. (Motion for adoption duly seconded.)

2. The Committee on Cancer has done some excellent work promoting the interest of the medical profession in cancer detection and prevention. The committee's recommendation that there be close liaison and adequate supervision between local medical groups and lay organizations interested in cancer control is concurred in. (Motion for adoption seconded by Dr. George R. Daniels.)

3. The report of the Committee on Chronic Illness is approved and the committee is commended for its excellent work in cooperating with the Governor's Committee on Chronic Illness. (Motion for adoption seconded by Dr. Cleon A. Nafe.)

4. The report of the Committee on Diabetes is approved. It is urged that there be more cooperation by local societies in the diabetes detection drives sponsored by the Committee on Diabetes. (Motion for adoption seconded by Dr. L. D. Bibler.)

5. The work of the Committee on Foot Hygiene is commended and approved.

6. The Committee on Hard of Hearing had no meeting during the year.

7. No report was received from the Committee on Heart Disease.

8. The Committee on Infantile Paralysis had nothing to report.

9. The report of the Committee on Mental Health is approved. It is recommended that the House of Delegates go on record as being opposed to any licensure of clinical psychologists on terms permitting them to treat mental illness. It is recommended that members of the state association interest themselves in local mental health organizations, specifically chapters of the Indiana Mental Hygiene Society, so as to help guide their activities on a sound medical basis. The supplemental report of the Committee on Mental Health is approved. We note with pleasure the appointment of Mr. Joe Brown as full-time director of the Mental Hygiene Society of Indiana. (Motion for adoption of this section seconded by Dr. George R. Daniels.)

10. The Committee on School Health and Physical Education has been very active this past year. Their theme of cooperation at a local level with school officials, dental and medical societies has shown satisfactory progress. Continued interest of local medical societies in this work is recommended. (Motion for adoption duly seconded.)

11. The report of the Committee on Traffic Safety is approved.

12. The report of the Committee on Tuberculosis is approved. It is recommended that the detailed guide for the follow-up on contacts of tuberculosis as recommended by the Committee on Tuberculosis of the state board of health be submitted to local societies for their guidance and use. (Motion for adoption of this section duly seconded.)

13. The report of the Committee on Venereal Disease is approved.

14. The resolution referred to this committee concerning the request of the Indiana Health Officers Association to form a Section on Preventive Medicine and Public Health within the Indiana

State Medical Association has been considered and is approved. (Motion for adoption of this section duly seconded.)

JAMES M. KIRTLEY, M.D., *Chairman*
GEORGE VAIL, M.D.
W. B. LYBROOK, M.D.
JOHN S. HASH, M.D.
MAX LONG, M.D.

(Dr. Kirtley's motion for adoption of this report as a whole was seconded unanimously.)

AMENDMENTS TO CONSTITUTION AND BY-LAWS

DR. AUGUSTUS P. HAUSS, chairman, presented the following report, which, on motion of Dr. Hauss, with seconds as shown, was adopted section by section and as a whole:

The report of the Committee on Constitution and By-laws is approved. (Motion for adoption seconded by Dr. W. H. Garner.)

1. *Resolution to make eligibility to senior membership 70 instead of 75 years.*

Sec. 4 of Article IV of the constitution is a part of the constitution and must be presented, published twice in THE JOURNAL and voted upon at the next annual meeting.

The following facts are respectfully called to your attention.

1. Many doctors over 70 years of age are in active practice.

2. Approximately 308 of our present members would be affected by this amendment.

3. This amendment would reduce the I.S.M.A. annual revenue from dues $10,780.

4. We further call your attention to the fact that Sec. 13 of Article XII of the by-laws states:

> "In the event the county society remits a member's dues for good cause, and the secretary of the county medical society recommends in writing the remission of the state association dues of said member of the society, and shows good cause why such recommendation should be granted, the Council shall have the power to remit such dues."

We recommend that this amendment to the constitution not be put upon its way to passage and that the resolution be disapproved. (Motion for adoption of this section duly seconded.)

2. *Resolution to give each section a delegate in the House of Delegates.* The committee feels that the sections are amply represented by the committees on Section and Section works, and all specialty fields of medicine are represented by the delegates of the county societies. Therefore the committee does not recommend the adoption of this resolution. (Motion for adoption seconded by Dr. J. M. Kirtley.)

3. *Resolution on reorganization of Councilor Districts to conform with Congressional Districts, requiring a change of by-laws.* The committee considers that this change may have some political value but would have the following disadvantages:

1. The loss of two (2) councilors.

2. Our present Councilor Districts were the former Congressional Districts and are thoroughly established in our statewide plan of medical organization. The present Congressional Districts are temporary and may be changed due to political maneuvering or changes of population.

3. Frequent changes of Councilor Districts would tend to break up established traditions of friendship and cooperation necessary for the most efficient functioning of professional groups.

4. Our present Councilor Districts contain from 4 to 10 county medical societies and are compact and readily accessible to all members thereof.

The proposed new Congressional Districts contain from one to 13 county medical societies, and the extreme borders of nearly 50 percent of these Congressional Districts are from one hundred to one hundred and fifty miles apart. And many of these new districts are impractical for councilor supervision and inconvenient for district meetings.

5. The committee feels that this change in districts would seriously affect the activities of many of our county medical societies.

6. Except in political contacts with the congressional district congressman, this committee found no evidence that there existed any increase in the amount of confusion in the conduct of the affairs of the association by the officers and executive employees of the state association with the present Councilor District organization.

The committee recommends that the above resolution be disapproved. (Motion for adoption of this section seconded by Dr. A. S. Giordano.)

4. *Resolution on reorganization of Councilor Districts requiring Constitutional amendment.* For the same reasons just given regarding the resolution to change councilor districts, the committee recommends that the resolution for the change of the constitution to make the constitution consistent with the resolution also be disapproved. (Seconded by Dr. A. S. Giordano.)

5. *Resolution to abolish office of alternate Councilor.* The committee believes that the original intention of having alternate councilors to train in organized medicine was good; however, few districts have used this opportunity, and we therefore approve the adoption of this resolution and move that this resolution be put upon its way for passage as an amendment to the constitution. (Motion duly seconded.)

6. *Resolution providing for a mid-year meeting of the House of Delegates.* The committee recommends the adoption of this resolution for the following reasons:

1. It will place the business of the association more in the House of Delegates, and thereby relieve the Council and Executive Committee of excessive interim responsibility.

2. It will enable the House of Delegates to meet in various geographical areas of the state, thereby giving the public greater knowledge of the importance and activities of the I.S.M.A.

3. Furthermore, it would enable more members to participate in and see their House of Delegates in action. (Motion for adoption seconded by Dr. L. D. Bibler.)

7. *Resolution to provide for Councilor meetings with county society officers and delegates.* The committee does not believe that at the present time this resolution should be made mandatory by an amendment to the by-laws.

The committee is in full accord and agreement with the intent and purpose of this resolution, and recommends that it be approved in principle by the House of Delegates, and be made effective to the extent that these meetings be on a voluntary basis. (Motion for adoption of this section seconded by Dr. John M. Paris.)

8. *Resolution to make Committee on Conference of Medical Society Officers a standing committee.* The committee approves the adoption of this resolution. (Motion for adoption of this section duly seconded.)

9. *Resolution which would make Committee on Physician-Patient Relations a standing committee and outlining its composition and duties.* The committee approves this resolution for adoption. (Seconded by Dr. W. U. Kennedy.)

10. *Resolution on election of chairman of Council and Executive Committee.* The committee recommends the adoption of this resolution. (Seconded by several.)

11. *Resolution on investment of surplus funds of the Indiana State Medical Association.* The committee recommends the adoption of this amendment to the by-laws. (Duly seconded.)

The Reference Committee on Amendments to Constitution and By-laws wishes to thank those who appeared in the hearings before the committee and presented valuable, informative data.

I move that this report as a whole be approved and adopted. (Motion seconded by Dr. George R. Daniels.)

Augustus P. Hauss, M.D., *Chairman*
J. L. Allen, M.D.
C. H. McCaskey, M.D.
I. E. Huckleberry, M.D.
Roy A. Geider, M.D.

REPORTS OF OFFICERS

DR. S. J. PETRONELLA, chairman, presented the following report:

Your Reference Committee on Reports of Officers met and reviewed the addresses of the president, and president-elect, and also examined and evaluated the reports of the following officers and committees, all of which were approved by the reference committee:

1. Report of Executive Secretary
2. Report of Treasurer
3. Report of Chairman of Council
4. Reports of Councilors
5. Report of Executive Committee
6. Report of Auditing Committee
7. Report of Editor of The Journal

Your reference committee wishes to commend most highly the president, for his excellent address, which is evidence in itself of the amount of time, energy, study, correspondence, travel, and personal sacrifice given in his devotion to our cause.

Your reference committee wishes to compliment the president-elect for his keen knowledge of the problems affecting the profession, and for his statement of policies, which will lead to the attainment of unity of purpose and application of sound principles, for the advancement of our profession, and the benefit of those we are privileged to serve.

Your reference committee regrets the untimely loss of Ray E. Smith, who so ably executed the duties of executive secretary, with diligence, thoroughness, efficiency, and always with a smile. A tremendous loss has been sustained, and he will be missed immensely.

Your reference committee also wishes to commend all other officers and committees on the excellent work they have done during the past year: the treasurer and Auditing Committee for a complete and satisfactory report, the chairman of the Council, Councilors, and Executive Committee for their untiring and successful efforts, and the staff of The Journal for a job well done and a journal second to none.

Your reference committee is fully cognizant of the fact that the reports presented could not possibly fully portray all of the activities representing the enormous amount of work performed; work which in many instances is time-consuming, inconvenient and of a thankless nature. It is for this reason, therefore, that we again express our gratitude to all those who have served.

We know we have been served by able, honest, conscientious and diligent workers. We also know our organization is well established and solvent. However, it should not only depend merely upon the interest and efforts of the officers and committees. No person alone, nor group of officers or committees, nor even body of delegates can solve the many problems with which we are daily confronted. Every individual member should become vitally concerned about the welfare of our association, and in the fulfillment of the desire of the profession, and the need of the public. This is a task to which every member of the Indiana State Medical Association must be committed in a spirit of individual cooperation and service, in order to preserve Hoosier and American Medicine.

I move the adoption of this report.

S. J. Petronella, M.D., *Chairman*,
H. P. Ross, M.D.,
M. H. Omstead, M.D.
Guy B. Ingwell, M.D.,
Norbert Welch, M.D.

(Motion for adoption of this report duly seconded, and report adopted.)

MISCELLANEOUS BUSINESS

DR. JOHN M. PARIS, chairman, presented the following report, which was adopted by sections and as a whole:

Mr. President and members of the House of Delegates, your Reference Committee on Miscellaneous Business has met and considered all of the matters referred to it. We have read the report of the Committee on Convention Arrangements and feel that Dr. J. Neill Garber and his committee have done an exceptionally fine job of getting the convention together and we wish to compliment them on this achievement. I move the adoption of this portion of the report.

Your reference committee has examined the report of the Committee on Civil Deferense and find it to be a very complete report and it shows that under the guidance of this committee a great deal of work has been done. However, the enormity of this situation is frightening and it is urged that the State Association, through its president, will urge, and even insist, that each county get busy immediately with plans of civil defense. I move the adoption of this portion of the report.

Your reference committee has examined the report of the Committee on Conference of County Medical Society Officers and approves it in its entirety. Mr. President, I move the adoption of this portion of the report.

Your reference committee has examined the report of the Indiana A.M.A. Campaign Coordinating Committee and wishes to commend Dr. Nafe and his committee for the fine work that it has done. Since this committee was organized just a few years ago, it has done a tremendous job and it has been very successful in leading us back to the democratic way of life. The reference committee wishes to recommend that this campaign coordinating committee become a standing committee in our State Organization because it will be a long, long time before the socialism idea in this country of ours is forgotten. Mr. President, this reference committee feels that the work of this coordinating committee is truly an example of Americanism at work. I move the adoption of this portion of the report.

Your reference committee has examined the report of the Committee on Indiana Inter-Professional Health Council and moves the adoption of it in its entirety. I so move.

Your reference committee has examined the report of the Committee on Military Manpower and the supplementary report and feels that it has the problem well in hand and we move the adoption of this portion of the report. I so move.

Your reference committee has examined the report of the Committee on Veterans' Affairs and Rehabilitation and notes with interest that there have been no complaints in the present year about improper charges on the part of our participating members. We commend all of us on this achievement and move the adoption of this portion of the report.

Your reference committee has examined the resolution regarding Veterans Hospitals which was introduced by Dr. Bibler and we recommend that it be referred to the standing Committee on Veterans affairs and a report be made by them to the next meeting of the House of Delegates.

Your reference committee has examined the resolution pertaining to Indiana Blue Cross and Blue Shield cooperation with the Veterans Administration to provide compensation to physicians and hospitals and feels that this resolution should not be approved, because this would add a heavy burden to the Blue Cross—Blue Shield organization and their representatives tell us that it is doubtful that such an arrangement could even be made with the VA. I move the adoption of this portion of the report.

Your reference committee has examined the resolution introduced by Dr. Catlett on the use of M.D. instead of Dr. when addressing physicians' mail. I move the adoption of this portion of the report. Your Reference Committee has examined the resolution introduced by Dr. Scamahorn pertaining to deferral of chiropractic students and approves its adoption. I so move.

Your reference committee has examined the memorandum from the A.M.A. Council on Medical Service pertaining to simplified insurance reporting forms and we move the adoption of this report.

Mr. President, I move the adoption of this report in its entirety.

John M. Paris, M.D., *Chairman*,
Lee J. Maris, M.D.,
H. T. Combs, M.D.,
Martin C. Heck, M.D.,
Jack Lockhart, M.D.

PREPAID MEDICAL INSURANCE

DR. WILLIAM C. REED, chairman, presented the following report, which was adopted section by section and as a whole, on motions by Dr. Reed, with seconds as shown:

1. Your Reference Committee on Prepaid Medical Insurance approves the report of the Committee on Prepaid Medical and Hospital Insurance with the addition of a phrase to the next to the last paragraph (page 31 of the Handbook) of the report. We recommend that this paragraph read as follows:

"Be It Further Resolved, That this Permanent Study Committee be appointed to replace the present

Committee on Prepaid Medical and Hospital Insurance, and such committee shall be composed of members who are not connected with either Blue Cross or Mutual Medical Insurance, Inc."

(Motion for adoption seconded by Dr. A. P. Hauss.)

2. That portion of the report of the Committee on Tuberculosis concerning Blue Cross hospital service was referred to your Reference Committee on Prepaid Medical Insurance. Your committee wishes to submit the following resolution—

Be It Resolved, That we favor calling the attention of Blue Cross Hospital Service to the apparent inequity of their benefits which allows only 14 days hospital benefit for cases of tuberculosis each year and no half benefits, with a request that they study the situation.

We would call their attention especially to cases of tuberculosis in which surgery is performed, and suggest that such patients at least should be entitled to the full thirty days' hospital service.

WILLIAM C. REED, M.D., *Chairman,*
WILLIAM H. GARNER, M.D.,
K. N. VENIS, M.D.,
G. K. HAMMERSLEY, M.D.

(Motion for adoption of report as a whole seconded by Dr. W. U. Kennedy.)

RESOLUTION OF APPRECIATION

Dr. John M. Paris presented the following resolutions, which were adopted, on motion of Drs. Paris and Daniels:

WHEREAS, the Indianapolis Medical Society has had a heavy responsibility as host organization for the 102nd annual session of the Indiana State Medical Association; and

WHEREAS, the said Indianapolis Medical Society has carried off its responsibility in commendable fashion to assure the success of the session both from a scientific and entertainment standpoint; and

WHEREAS, the delegates, members and guests of the Indiana State Medical Association realize the amount of time and effort which is necessary for the staging of a meeting of this size; now,

Therefore Be It Resolved, That the House of Delegates of the Indiana State Medical Association does, in convention assembled, extend to the Indianapolis Medical Society its heartfelt thanks and great appreciation for the success of this, the 102nd annual session.

Be It Further Resolved, That this House of Delegates extend its official thanks to *The Indianapolis Star, Indianapolis News, Indianapolis Times,* the Associated Press, United Press, International News Service and the various radio stations for their splendid coverage and cooperation during this annual session.

MEMORIAL RESOLUTIONS

1. *To Dr. John W. Strange, Loogootee.* Dr. O. T. Scamahorn presented the following resolution, which was adopted on motion of Drs. Scamahorn and Robert H. Rang:

WHEREAS, in the sudden and untimely death of Dr. John W. Strange, the medical profession has lost one of its stalwart pioneers, whose untiring efforts and devotion to duty has entitled him to the lasting gratitude of the profession,

WHEREAS, the medical profession of the state of Indiana took particular pride in acknowledging his accomplishments in selecting him as the General Practitioner of the Year in 1950,

Now Therefore Be It Resolved, That the permanent records of the Indiana State Medical Association include this resolution in which is incorporated the following statement regarding him.

Dr. John W. Strange was born in Martin County on April 21, 1876, the second son in a family of eleven children. He grew to manhood in the community of Bramble and was educated in the county schools. He attended Martin County Normal School of Mitchell, Indiana. In 1899 he enrolled in the Medical College of Indiana at Indianapolis and graduated April 17, 1903, receiving his M.D. degree. In 1904 he opened an office in Loogootee and had lived and practiced there until the time of his death.

Dr. Strange was probably the best known and well-loved man in Martin County. In his large practice in both Martin and Daviess counties he had delivered over 5,200 babies. In a number of cases he had served as "family doctor" for four generations. He began his practice in the "horse and buggy" days of medicine and often told many interesting stories of the hardships and privations of practice in those times. He lived during the transition period from horses to automobiles and for many years after he owned a car he kept his horses for use when the roads were impassable. He often told many amusing accounts of his experiences in his first automobile.

In September 1950 Dr. Strange was chosen as "General Practitioner of the Year" for the state of Indiana by the Indiana State Medical Association. Dr. Strange took an active interest in medical as well as civic activities in the community. He was a member of the Martin-Daviess County Medical Society, the Indiana State Medical Association, the American Medical Association and the American Academy of General Practice. He had served three terms as county coroner and was County Health Officer at the time of his death. During World War I he was Mayor of Loogootee. His children included a priest, a nun and a physician.

Dr. Strange gave unsparingly of his time and energy to the service of his patients in the community and his death is a severe loss to those he served. He never failed to respond to a sick call and often made calls to his patients under severe handicaps of weather and the rigors of a country practice. His death occurred while he was returning from such a call on a sick baby, October 15, 1951.

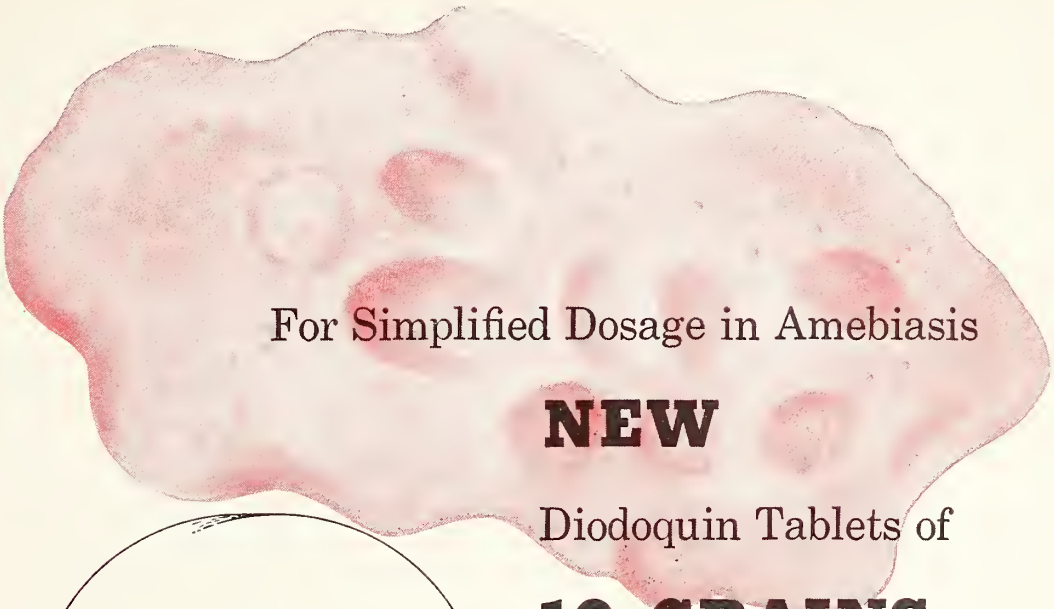
Be It Further Resolved, That a copy of this resolution be sent to his surviving sons, Rev. Raymond J. Strange, S.J., and Lt. Col. Hubert E. Strange, and his daughters, Mrs. Alberta Matthews and Mrs. Monica O'Brian, with the sympathy and condolence of the members of the Indiana State Medical Association.

2. *To Ray E. Smith, Indianapolis:* Dr. Cleon A. Nafe presented the following resolution:

Sadness over the death of our executive secretary, Ray E. Smith, reigns over this 102nd annual session of the Indiana State Medical Association.

On August 4 death suddenly and without warning removed from our ranks a fine friend of medicine. It was at our annual sessions that Ray displayed real ability for organization and tact. His driving energy and personal attention to details always assured a successful session. Now his absence leaves a certain vacuum.

Ray became executive secretary of our association on May 1, 1946, after serving as the first executive secretary of the Indianapolis Medical Society. He came into this type of work following a successful career first in journalism and later in public office. He earned and enjoyed the high respect of many prominent journalists and of high public officials of



For Simplified Dosage in Amebiasis

NEW

Diodoquin Tablets of

10 GRAINS

(650 mg.)

SEARLE

With the introduction of a new 10-grain (650 mg.) tablet of Diodoquin, the number of tablets necessary for treatment of amebiasis can be reduced from ten a day to three a day.

Thus the twenty-day recommended dosage schedule is accomplished with a total of 60 instead of 200 tablets. The cost to the patient is reduced accordingly.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

A potent oral amebacide— **DIODOQUIN®**

(*diiodohydroxyquinoline*)

—is a well-tolerated, relatively nontoxic compound containing 63.9 per cent of iodine.

Now available in tablets of:

3.2 grains (210 mg.), bottles of 100 and 1,000
10 grains (650 mg.), bottles of 60 and 500

Be sure to prescribe the 10 gr. (650 mg.) size for full adult dosage.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

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both political parties, even though he had always been identified as a Democrat.

In this new secretarial post Ray made many friends in the field of medicine, both nation-wide and throughout Indiana. He was well respected by officials of the American Medical Association and by leaders in many of the other state medical societies.

Ray had a sincere high regard for the medical profession, yet was one of the first to recognize shortcomings of a few of its members and quietly but earnestly sought ways and means of correcting them. He was methodical, diligent and somewhat retiring. He did not crave the limelight. He spent long hours in behalf of the profession and seldom was his mind free of many of our complex problems. Ray wanted the medical profession to enjoy and to deserve high public esteem and, above all, he felt a public responsibility in seeing that all of our people had good medical care.

He was modest, kindly, and enjoyed a pleasant family life with his wife and twin daughters who survive him.

Medicine has lost one of its best friends, Indiana an honorable and respected citizen. Those of us who knew him well will cherish his memory. His kindliness and spirit will continue to live with us in the years ahead.

CLEON A. NAFE, M.D., *Chairman,*
C. S. BLACK, M.D.,
A. P. HAUSS, M.D.

I move that this memorial be adopted as an expression from this House of Delegates, that it be made a part of the permanent record of our association and that copies be sent to his widow and two daughters.

(Motion seconded by Dr. Daniels and resolution adopted on standing vote.)

3. *To John F. Hayes, Washington, D. C.:* Dr. J. W. Denny presented the following resolution, which was adopted on motion of Drs. Denny and Daniels:

WHEREAS, in the death of John F. Hayes, the medical profession has lost a friend and champion whose wise and valiant efforts on its behalf have entitled him to the lasting gratitude of the profession; and,

WHEREAS, the medical profession of the state of Indiana in particular takes special pride in the fact that he was born in this state, and for that reason would like to have the privilege of initiating the action through which a memorial to him may be preserved not only in the records of the Indiana State Medical Association, but also in the records of the American Medical Association,

Now, Therefore, Be It Resolved That the permanent records of the Indiana State Medical Association shall include this resolution in which is incorporated the following statement regarding him;

John F. Hayes, whose death occurred on September 17, 1951, leaves an inspiring record of achievements which have made the country, and particularly the medical profession of America, deeply his debtor. He was born in Indiana and graduated from the Indiana Law School in 1898. He expected from his childhood to earn his way in the world and not have it opened out before him because of the fortunes of birth or the favors of gratuitous patronage. He became a competent stenographer and in that capacity was employed by the late Senator Albert J. Beveridge, whose achievements have entitled him also to undying fame as one of the great statesmen and authors of America.

Mr. Hayes was not content to do what was merely within the call of the duty of his employment. Beyond the call of only that duty he studied intensively the subjects covered by his stenographic notes. He not only did the manual work of typing, but contributed brilliantly to the very language of such legislation as the Federal Meat Inspection Act, the Tariff Commission Act, and child labor legislation.

This country could not function and our liberties be preserved if people were indifferent to politics. It is the means through which self-government is carried on. From 1909 to 1912, Mr. Hayes was the secretary of the Indiana State Republican Committee. Senator James E. Watson of Indiana, upon being elected to the Senate in 1916, appointed Mr. Hayes as his secretary, in which position he served until 1933, when he entered into the law practice in Washington, which he continued until his death.

For many years he was associated with the Bureau of Legal Medicine and Legislation of the American Medical Association, in which position he served with the same quiet, unostentatious efficiency as in every other position he occupied.

The life and work of Mr. Hayes stands as the proof that modesty and contentment with one's own soul's applause may be retained by a person and still that person may render a distinguished political service in America. Senator Watson said of him, "To the ability and industry of John F. Hayes in the discharge of his duties, I owe much of my success in public life."

The name of John F. Hayes should be cherished in the memory of the medical profession of Indiana and of the whole United States, and of all who knew him or may ever read this memorial—as a man who has in quietness and modesty demonstrated, to the inspiration of all, how much may be accomplished through "one man's plain truth to manhood and to God's supreme design."

And Be It Further Resolved That the Indiana Delegation to the House of Delegates of the American Medical Association be authorized and instructed to present a motion in that House to adopt a resolution to accept and make a part of the records of that Association, the memorial to John F. Hayes contained in this resolution.

And Be It Further Resolved That a copy of this resolution be sent to his widow, Mrs. Mary Carson Hayes, and to his son, John Hamilton Hayes, with the sympathy and condolence of the members of the Indiana State Medical Association.

J. W. DENNY, M.D., *Chairman.*
W. H. HOWARD, M.D.,
A. A. THOMPSON, M.D.

APPRECIATION OF PRESIDENT

Dr. A. S. Giordano presented the following resolution, which was seconded by Dr. Cleon A. Nafe and adopted on a rising vote:

WHEREAS, each year sees an increasing amount of work and responsibility placed on the office of president of the Indiana State Medical Association; and,

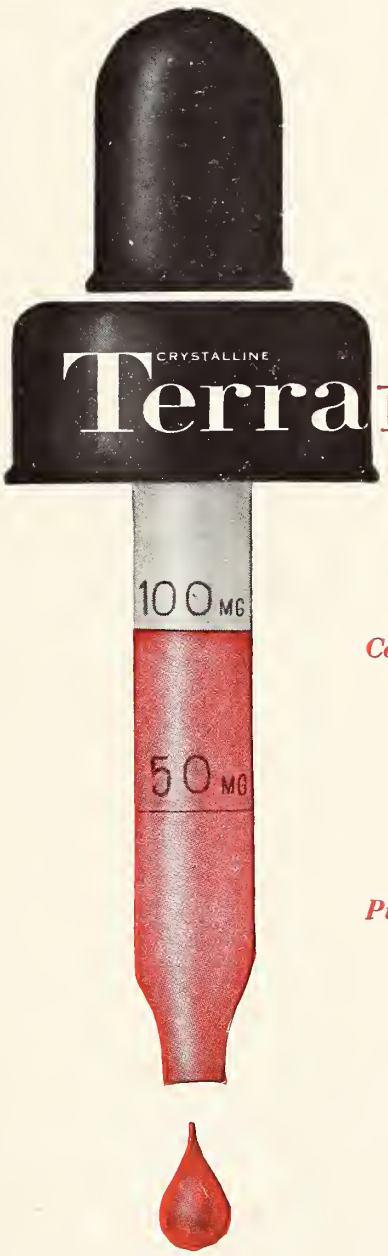
WHEREAS, these responsibilities have been met with dignity and distinction, and

WHEREAS, this activity has concerned itself with all phases of the scientific aspects and the lay relationship phase of business of the Association, thus

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only **Terramycin** *in liquid concentrate for optimal convenience*

Crystalline Terramycin Hydrochloride Oral Drops provide 50 mg. in each 9 drops—or 200 mg. per cc.—a concentration affording optimal simplicity and convenience in dosage.



Can be taken "as is" or mixed with foods and fluids

These potent drops for oral administration are completely miscible with most foods, milk and fruit juices, thus permitting a further simplification in the therapeutic regimen.

Pure crystalline antibiotic—well tolerated

Terramycin Oral Drops are prepared from pure crystalline material. As with other dosage forms of this effective broad-spectrum antibiotic, Terramycin Oral Drops are well tolerated.

Supplied: 2.0 Gm. with 10 cc. of diluent, and specially calibrated dropper.

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requiring important and sometimes rapid judgment on questions affecting the welfare of the entire medical profession of the State of Indiana; and

WHEREAS, all of these activities have been met with rare tact on the part of the incumbent in the office of president; now

Therefore Be It Resolved That the House of Delegates of the Indiana State Medical Association in convention assembled does hereby extend to Dr. Alfred Ellison, of South Bend, its unanimous and sincere appreciation for his excellent efforts in its behalf during the term of his office; and,

Be It Further Resolved, That this token of appreciation shall be spread upon the minutes of this Association as a permanent record.

ELECTION OF A.M.A. DELEGATE TO FILL UNEXPIRED TERM OF DR. A. S. GIORDANO, SOUTH BEND

Dr. A. S. Giordano presented his resignation as delegate to the American Medical Association and nominated Dr. Alfred Ellison to fill his unexpired term, ending December 31, 1952. Motion of Dr. Giordano for suspension of the rules was carried on voice vote, and Dr. Ellison was elected to fill Dr. Giordano's unexpired term as delegate to the American Medical Association. Dr. Giordano's resignation is effective as of January 1, 1952.

THE PRESIDENT: I thank you very sincerely.

No further business appearing, on motion of Dr. George Daniels, duly seconded, the House adjourned *sine die.*

EXECUTIVE COMMITTEE

September 23, 1951

Roll call showed the following present: W. L. Portteus, M.D., chairman; Alfred Ellison, M.D.; J. William Wright, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; James A. Waggener, field secretary, and Lucille Kribs, acting executive secretary.

Guests: E. S. Jones, M.D., chairman; E. B. Lamb, M.D., and L. W. Spolyar, M.D., Committee on Industrial Health. L. Edward Gaul, M.D., chairman; G. B. Underwood, M.D., George Garceau, M.D., and R. M. McDonald, M.D., Committee on Foot Hygiene.

Membership Report

Number of members September 18, 1951	3,599*
Number of members September 18, 1950	3,625
Loss over last year	26
Number of members December 31, 1950	3,689

*Includes 46 in military service (gratis)
139—$10.00 members (residents and interns)
208—senior members
36—members, dues remitted by Council

Number who have paid 1951 AMA dues	2,852
Number who have paid 1950 AMA dues	2,857

Treasurer's Office

On motion of Drs. Myers and Wright, the $4,000.00 received from matured City Hospital bonds is to be invested in United States Savings Bonds, Series G.

Statements of receipts and expenditures and report on the budget for July and August for the association and THE JOURNAL were approved.

1951 Annual Session, Indianapolis October 29, 30 and 31, 1951

Request of Lyman R. Bradley, New York, "entrepreneur in book exhibits," for space and designation as "sole combined book exhibitor" was refused, as all booths have been reserved and as several large medical book publishers have been exhibitors for many years in the past and probably will continue to attend Indiana medical conventions.

Personal liability insurance. It was taken by consent that a personal liability insurance policy covering the 1951 convention at the Murat Temple and the banquet at the Indiana ballroom should be procured.

Stag Party

On motion of Drs. Myers and Wright, the president and president-elect of the Indiana Student A.M.A. are to be invited to the stag party.

Each company represented in the technical exhibit is to be given two complimentary stag party tickets.

Senior medical students and such other medical students as may desire to attend are to be invited to the convention, including the president and secretary, or president-elect, of the Indiana Student A.M.A.

President's night. The Indianapolis Medical Society is to be asked to assist in making up the invitation list for this event. The medical students are to be invited to the Tuesday evening program.

Organization Matters

On motion of Drs. Ellison and Wright, the committee granted the request of Dr. Norman Booher to use THE JOURNAL mailing list to send a letter of invitation and program of the April 1952 meeting of the Indiana Academy of General Practice to all members of the Indiana State Medical Association.

Standing orders for nurses in industry.

a. Drs. Jones, Lamb and Spolyar reviewed the work over the past four or five years, of the Committee on Industrial Health in drawing up a book of standing orders for nurses in industry, detailed report of which previously had been sent to each member of the Executive Committee. On motion of Drs. Ellison and Wright, the committee approved the report and congratulated and thanked the Committee on Industrial Health for the tremendous amount of work it has done. To supply every physician, every industrial nurse, and each

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industry in the state with a copy of this booklet will require from $3,000 to $5,000. The Committee on Industrial Health is to compile an estimate of the printing and distribution costs for presentation to the Executive Committee at its next meeting. The Executive Committee is to recommend to the Council that a sum to be decided upon be allowed the Committee on Industrial Health for publication and distribution of this pamphlet.

b. Letter received from a New Albany physician asking for recommendations of the association and legal opinion regarding standing orders for registered industrial nurses answered by Albert Stump. A copy of the preliminary report of the Committee on Industrial Health is to be sent to this physician.

Simplified insurance reporting forms. On motion of Drs. Wright and Ellison, simplified insurance reporting forms, submitted and approved by the Council on Medical Service of the American Medical Association, were accepted by the committee and are to be referred to the Council for its approval and then to the House of Delegates, in order that they may be ratified at the A.M.A. interim session in December.

Request of the Indiana Heart Foundation, Inc., to enclose monthly bulletin from the American Heart Association in ISMA News Flashes was denied on the basis that to do this would be setting a precedent which might involve some difficulties in the future and probably would increase mailing costs. This action was taken on motion of Drs. Wright and Ellison.

Indiana ANP Committee on Hospital Relationships. Mr. Stump, temporary chairman, submitted the following report:

"On August 29 representatives of the State Hospital, Nurses and Medical Associations met and perfected the organization of a Committee on Hospital Relations made up of three members of each association. All the members appointed by the respective associations to accept positions on the Committee were present except one nurse, who was gone on vacation, but the Nurses Association was represented by two appointed members of their Committee and by their President and Secretary.

"A full report of the transactions of that date will be given in the minutes that will be submitted to all the members of the Committee and the Secretaries of the three associations. Miss MacDougall, of the Nurses Association, was elected chairman of the Committee. The work to be undertaken by the Committee will be of an advisory nature. Their purpose will be to cooperate in improving hospital care, particularly through avoiding dissension and conflict among those who serve in the management, the nursing and the treatment of patients in the hospitals.

"High hopes were expressed in the meeting that much good would be accomplished and that all three associations would profit as a result of the activities of the Committee through improved public relations as well as improved relations among the groups represented on the Committee."

On motion of Drs. Myers and Wright, the Indiana Heart Foundation was given permission to use THE JOURNAL mailing list to secure subscriptions for *Circulation*, official publication of the American Heart Foundation.

Report of Committee on Foot Hygiene. Drs. L. Edward Gaul, chairman, George Garceau, G. B. Underwood and R. M. McDonald, members of the Committee on Foot Hygiene, appeared before the Executive Committee and told of the work of the committee in investigating and studying the possibilities of putting on the market a shoe that definitely will not produce a dermatitis. The Executive Committee felt that it, or the state association, should not be placed in the position of sanctioning rebates, or of certifying any specific shoe company's products. On motion of Drs. Ellison and Wright the Executive Committee gave authority to the Committee on Foot Hygiene to submit its idea to the Council on Physical Medicine of the American Medical Association for approval and sanction of the Council. During the discussion it was brought out that the annual report of the Committee on Foot Hygiene would be approved, or disapproved, by the House of Delegates during the annual session and, if approved, it then could be sent to the American Medical Association with the blessing of the state association.

Future Meetings

On motion of Drs. Wright and Ellison, the field secretary was authorized to attend the 36th annual luncheon meeting of the Directors and Staff of the Better Business Bureau at the Claypool Hotel, Indianapolis, September 27, 1951.

Centennial convention, Kentucky State Medical Association, Louisville, October 2, 3, 4 and 5, 1951, to be attended by Doctor Wright and Dr. A. P. Hauss.

State Chamber of Commerce Board of Directors' meeting, French Lick, October 5, 6, 7, 1951, to be attended by the field secretary, on motion of Drs. Wright and Portteus.

A.M.A. Public Relations meeting, Los Angeles, December 2 and 3, 1951. Dr. Earl W. Mericle, chairman of the Committee on Public Relations, is to represent the state medical association at this meeting.

A.M.A. Clinical Session, Los Angeles, December 4 to 7, 1951.

a. *Association headquarters.* By consent, the committee voted that the state association should not have a headquarters room during the Los Angeles Clinical Session.

You may prescribe "RAMSES"† Vaginal Jelly with full confidence in its safety and effectiveness. No vaginal jelly available provides a greater degree of spermicidal or barrier action than does "RAMSES" Vaginal Jelly.

IMMOBILIZES SPERM IN THE *FASTEST TIME* RECOGNIZED FOR CHEMICAL CONTRACEPTIVES*



* This immobilization time is measured by the Brown and Gamble technique, the only method accepted by the Advisory Committee on Contraceptives of the Council on Pharmacy and Chemistry of the American Medical Association for determining the sperm immobilization time of chemical contraceptives.

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quality first since 1883

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b. *Special tour.* It was taken by consent that a special tour in connection with the Clinical Session should not be offered.

Medical Civil Defense Conference, Chicago, November 9 and 10, 1951. The chairman of the Committee on Civil Defense was authorized to attend this meeting.

The Journal

Report on advertising.

Total, first nine months, 1950	$19,929.12
Total, first nine months, 1951	20,612.38
Gain in 1951	683.26

There being no further business, the committee adjourned to meet again at 6:30 p.m., Sunday, October 28, at the Columbia Club, Indianapolis.

EXECUTIVE COMMITTEE

October 28, 1951.

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; Alfred Ellison, M.D.; J. William Wright, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; James A. Waggener, field secretary, and Lucille Kribs, acting executive secretary.

Guests: Council Screening Committee: E. H. Clauser, M.D., chairman; Elton R. Clarke, M.D.; W. H. Howard, M.D., and Roy Geider, M.D.

Membership Report

Number of members October 23, 1951	3,620*
Number of members October 31, 1950	3,651
Loss over last year	31
Number of members December 31, 1950	3,689

* Includes 46 in military service (gratis)
149—$10.00 members (residents and interns)
208—senior members
36—members, dues remitted by Council

Number who have paid 1951 A.M.A. dues	2,873
Number who have paid 1950 A.M.A. dues	2,860

Treasurer's Office

Proposed amendment to By-laws. On motion of Drs. Clark and Wright, the amendment to the By-laws, proposed by the treasurer, specifying securities in which the association's surplus funds shall be invested was approved. This change in the By-laws is to be recommended to the Council.

1951 Annual Session, Indianapolis, October 29, 30 and 31, 1951

Scientific exhibitors' expenses. On motion of Drs. Ellison and Clark, small incidental expenses of scientific exhibitors are to be paid by the state association.

Statements of receipts and expenditures and report on the budget for September for the association and THE JOURNAL were approved.

1953 Annual Session

Letter from Dr. Phillip T. Hodgin, Orleans, president of the Orange County Medical Society, inviting the association to hold its 1953 annual convention at French Lick, was read. A similar letter from the French Lick Springs Hotel also was read.

October 19, 20 and 21, 1953, are the tentative dates set with the French Lick Springs Hotel.

Legislative Matters

National

American Legion convention, Miami. The field secretary gave a brief report on the American Legion convention which was held in Miami.

Local

Experimental animal supply problem and new Indiana law. Letter from the executive secretary of the National Society for Medical Research, Chicago, suggesting consideration of a definite, unified program for the utilization of the new Indiana law providing that local pound masters may dispose of unclaimed animals as they see fit, was read. The committee expressed the feeling that this is a matter for Indiana University School of Medicine and that the state medical association should cooperate in any way possible.

Organization Matters

Standing orders for nurses in industry. Dr. E. S. Jones, chairman of the Committee on Industrial Health, appeared before the committee to present costs of printing this pamphlet, as follows: $156.00 for 5,000; $290.00 for 10,000 copies with special cover.

On motion of Drs. Clark, Wright and Myers, the printing of these orders was turned over to Dr. Ramsey, to handle as he sees fit. The Executive Committee is to recommend to the Council that $290.00 and a sum to cover distribution costs be appropriated to the Committee on Industrial Health for this purpose.

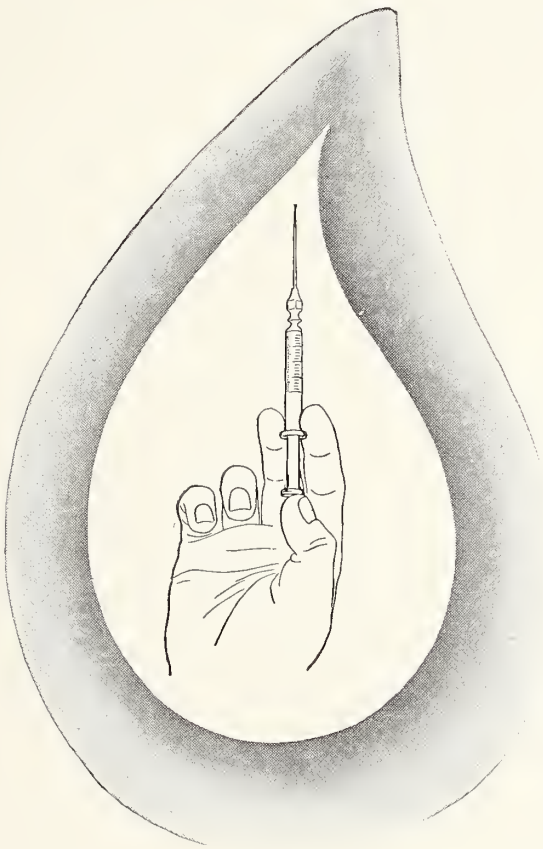
1952 dues in Conference of Presidents and Other Officers of State Medical Associations. On motion of Drs. Ellison and Clark, $50.00 is to be sent to this organization for 1952 dues.

On motion of Drs. Ellison and Kennedy, Norways Foundation, Indianapolis, was given permission to use THE JOURNAL mailing plates for distribution of *Norways Quarterly* with the understanding that the Foundation's use of these plates does not conflict with the association's use of them.

On motion of Drs. Wright and Ellison, the committee voted to continue membership in the Indiana State Chamber of Commerce at $100.00 per year.

On motion of Drs. Kennedy and Clark, the request of Mutual Medical Insurance, Inc., to reprint the action of the special session of the House of Delegates, held in Indianapolis, January 27, 1946,

Dihydrostreptomycin Sulfate



a Drug of Choice

for Physician and Patient

Extremely well tolerated and rarely causing irritation on injection, Dihydrostreptomycin Sulfate has become a most widely accepted streptomycin preparation.

***Comparative studies by leading clinicians confirm that* DIHYDROSTREPTOMYCIN SULFATE IS—**

as effective as streptomycin [2, 9, 13-15]

less toxic for the vestibular apparatus [1-15]

minimizes pain and swelling at the site of injection [6, 10]

may be used even in patients showing allergic response to streptomycin [2, 9, 10, 11]

Extensive experimental studies [6, 9, 16-18] ***proved* CRYSTALLINE DIHYDROSTREPTOMYCIN SULFATE MERCK *less toxic for the vestibular system.***

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Crystalline Dihydrostreptomycin Sulfate Merck is supplied in convenient 1 Gm. and 5 Gm. vials.

MERCK & CO., INC.
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and published in the March, 1946, issue of THE JOURNAL, was granted.

On motion of Drs. Ellison and Clark, the committee approved publication of an article in MEDICAL ECONOMICS on the field secretary's work, if the field secretary sees fit to submit such an article.

Future Meetings

November 16, 1951—Indiana State Chamber of Commerce annual meeting, Murat Temple, Indianapolis. On motion of Drs. Kennedy and Ellison, the president-elect was authorized to attend this noon luncheon meeting.

December 2-3, 1951—A.M.A. Public Relations meeting, Los Angeles. On motion of Drs. Clark and Wright, the field secretary is to attend this meeting, in addition to Dr. Earl W. Mericle.

The Journal

Report on advertising:

Total, first ten months, 1951	$23,477.28
Total, first ten months, 1950	22,265.02
Gain in 1951	1,212.26

There being no further business, the committee adjourned to meet again upon the call of the chairman.

Help Preserve Medical Education

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LOCAL SOCIETY REPORTS

Clay County Medical Society members met at the Elks Club in Brazil on October 16. This was a general business meeting, and six members were present.

Fayette-Franklin County Medical Society members held a meeting at the Connersville Country Club, when the guest speaker was Dr. Samuel Trufant, of Cincinnati. His subject was "Convulsions." Fifteen members and two guests attended the meeting.

Floyd County Medical Society members met in New Albany on October 12. The fourteen members who were present discussed Diabetic Detection Week.

LaPorte County Medical Society members met at the Trail Inn at Michigan City, on October 18. Dr. R. W. Gilmore of Michigan City spoke on "Subdural Hematomas"; Dr. George Von Asch, of LaPorte, spoke on "Boeck's Sarcoid"; and Dr. G. O. Larson, of LaPorte, gave a report on the School Health Conference. Twenty-six members were present.

Ripley County Medical Society members met at Sunman on October 23. Dr. Charles Overpeck of Greensburg was the guest speaker. Five members were present.

Vanderburgh County Medical Society members met at the Hotel McCurdy in Evansville on November 13. Dr. Samuel R. Warson, of Indiana University School of Medicine, spoke on "Child Psychiatry and Child Guidance."

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THE JOURNAL

OF THE

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